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ed for burial permit
Board of Health
its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

PLACE OF DEATH

1

Suffolk
(County)
Winthrop
(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

8-28762

(City or Town making this return)

Registered No. 1

No. 17 Hillside Ave.

{ (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME DAVID E. DOMEY

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{ (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 72 Autumn St., Lynn
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years months 1 days. In place of residence 51 years 11 months 2 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 1, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Acute myocardial infarction.

5 Accident, suicide, or homicide (specify)
Date and hour of injury 19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did injury occur?
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?
(Specify type of place)

Manner of injury
(How did injury occur?)

Nature of injury
While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased?

If so, specify
(Signed) Michael A. Monge, M.D.
(Print or Type Name)

(Address) Boston, Mass. Date 1/1 1963

7 ST. Marys
Place of Burial, or Cremation, Lynn
(City or Town)

DATE OF BURIAL Jan 4 1963

8 NAME OF FUNERAL DIRECTOR Charles A. Wall

ADDRESS 103 Johnson St. Lynn

Received and filed JAN 2 1963 19.....

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR white 11 SINGLE (write the word) MARRIED
WIDOWED married
DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of Louise Webber
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH Jan. 29, 1911

14 AGE 51 Years 11 Months 2 Days If under 24 hours Hours Minutes

15 Usual Occupation Truck Driver
(Kind of work done during most of working life)

16 Industry or Business Dispatch Co.

17 Social Security No. 706 05 8491

18 BIRTHPLACE (City) Lynn
(State or country) Mass.

19 NAME OF FATHER Frank Domey

20 BIRTHPLACE OF FATHER (City) ST. Albans
(State or country) Vermont

21 MAIDEN NAME OF MOTHER Catherine Callahan

22 BIRTHPLACE OF MOTHER (City) Co. Limerick
(State or country) Ireland

23 Informant David A. Domey
(Address) 29 Saunders Rd. Lynn

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Galvin E. Lissauer
(Signature of Agent of Board of Health or other)

Neale Officer 1/2/63
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER

JAN - 21 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
L CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

tions, if any,
gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 39 Grovers Ave



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 2

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

2 FULL NAME. **Dulcie Mahoney**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

11 Bowdoin St
(a) Residence. No. **136 Cottage Park Road**
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....year **10**.....months.....days. In place of residence **25**.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **January 6, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June, 19**51**, to **6 Jan**, 19**63**
I first saw her alive on **6 Jan**, 19**63**, death is said to
have occurred on the date stated above, at **6:45 P.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Coronary Occlusion** **36 hrs**
(b) **Arteriosclerotic Heart Disease** **10 yrs**
(c) **Generalized Arteriosclerosis** **10 yrs**

OTHER SIGNIFICANT CONDITIONS **Cerebro-vascular Incident 1 yr with hemiplegia**

Was autopsy performed? **no**
What test confirmed diagnosis? **clinical observation**

5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify

(Signature) **Arthur C. Murray**, M. D.
Arthur C. Murray
(Print or Type Name)
(Address) **Winthrop** Date **7 Jan 1963**

6 **Winthrop** **Winthrop**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **January 9** 19**63**

7 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**

ADDRESS **Winthrop Mass.**

Received and filed **JAN 8 1963** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of **James F. Mahoney**
(Give maiden name of wife in full)
(or) WIFE of **James F. Mahoney**
(Husband's name in full)

12 AGE **72** Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: **Housewife**
(Kind of work done during most working life)

14 Industry or Business: **Own Home**

15 Social Security No.....

16 BIRTHPLACE (City) **Nottingham**
(State or country) **England**

17 NAME OF FATHER **Frederick Plumbley**

18 BIRTHPLACE OF FATHER (City).....
(State or country) **England**

19 MAIDEN NAME OF MOTHER **Ann Smith**

20 BIRTHPLACE OF MOTHER (City).....
(State or country) **England**

21 Informant **Barbara Cox**
(Address)
136 Cottage Park Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph H. Sullivan
(Signature of Agent of Board of Health or other)
Health Officer
(Official Designation) **January 8, 1963**
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

JAN - 8 1963 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 3

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



No. WINTHROP COMMUNITY HOSPITAL

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

KATHERINE LEITCH

(If deceased is a married, widowed or divorced woman, give also maiden name.)

nee: McDonald

(Was deceased a
U. S. War Veteran,
if so specify WAR)

NO.

26 Cliff Avenue, Winthrop

(a) Residence, No.

WINTHROP COMMUNITY HOSPITAL

St. WINTHROP MASS

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 3.....days. In place of residence 52.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHDE JAN. 9, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from

DEC 26, 1962, to JANUARY 9, 1963

I last saw him alive on JAN 9, 1963, death is said to

have occurred on the date stated above, at 1:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC FAILURE

INTERVAL
BETWEEN
ONSET AND
DEATH

3 WKS

Due To

(b)

CORONARY THROMBOSIS

3 WKS

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

NO

What test confirmed diagnosis?

ELECTROCARDIOGRAM

5 Was disease or injury in any way related to occupation of deceased?

NO

If so, specify

(Signature) A. N. Caplan, M. D.

A. N. CAPLAN, M.D.

(Print or Type Name)

(Address) 116 B. MAINT. WINTHROP MASS

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 11, 1963

7 NAME OF

FUNERAL DIRECTOR

Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed

JAN 11 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED widowed
WIDOWED
DIVORCED
UNKNOWN

female white

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Lewis Seaborn Leitch

(Husband's name in full)

12

AGE 71 Years

8 Months

5 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

housework

(Kind of work done during most working life)

14 Industry

or Business:

own home

15 Social Security No.

029-05-6958-A

16 BIRTHPLACE (City)

Boston

(State or country)

Massachusetts

17 NAME OF

FATHER

James McDon ld

18

BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19

MAIDEN NAME

OF MOTHER

unable to obtain

20

BIRTHPLACE OF

MOTHER (City)

(State or country)

England

21 Informant

(Address)

Mrs. Robert V. Atcherley

164 Woodside Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Serrano (R)

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

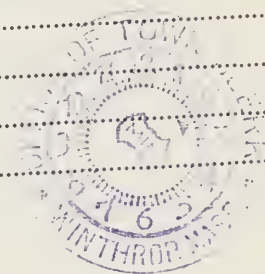
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

FORM R-301

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 4

No. Mount's Convalescent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lillian Nancy Foley (McCormick)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) 10.

(a) Residence, No. Trident Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 5 years 6 months days. In place of residence 55 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 10 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from DEC 13 1963 to JAN 10 1963
I last saw her alive on JAN 10 1963, death is said to have occurred on the date stated above, at 2 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS BMOS

Due To (b) ADENOCARCINOMA OF SPLEEN LYND.

Due To (c)

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITES 5YRS.
ARTERIO-SCLEROSIS - GEN. 5YRS.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & PATH.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King M.D.
Myron N. King M.D.
(Print or Type Name)

(Address) 222 Pleasant St. Date 1/12 1963
Winthrop

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 14, 1963 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
174 Winthrop St. Winthrop, Mass.
ADDRESS

Received and filed JAN 14 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Timothy Foley (Husband's name in full)

12 AGE 80 years 7 Months 23 Days If under 24 hours Hours Minutes

13 Usual Occupation housewife (Kind of work done during most working life)

14 Industry or Business own home

15 Social Security No. none

16 BIRTHPLACE (City) Boston Mass.
(State or country)

17 NAME OF FATHER James McCormick

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary Daley

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Old Age Dept.
(Address)

Winthrop, Massachusetts

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Smith
(Signature of Agent of Board of Health or other)

Health Officer Date 14-1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED
JAN 14 1963 AM
OFFICE OF THE
JAN 14 1963
WINTHROP

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 45, Sec. 12, G. L.)

50M-9-59-326111

PLACE OF DEATH

1

Essex
(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 5

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bertha Hollis
(If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR.)(a) Residence. No. 167 Shore Drive Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 20 months 20 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 11, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1962 to January 11, 1963
I last saw him alive on January 11, 1963 death is said to have occurred on the date stated above, at 2:50p. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Viral Pneumonia

Due General Arteriosclerosis
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Willard M. Hausman, M.D.
(Address) Hathorne, Mass. 1/15/636 Beachmont Cemetery, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 13, 1963

7 NAME OF FUNERAL DIRECTOR Torf Funeral Home
ADDRESS Chelsea, Mass.

Received and filed FEB 6 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED widowed

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Julius Hollis (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years 2 Months 24 Days If under 24 hours Hours Minutes

13 Usual Occupation: Sales Clerk (Kind of work done during most of working life)

14 Industry or Business: Not Determined

15 Social Security No.

16 BIRTHPLACE (City) Russia (State or country)

17 NAME OF FATHER Morris Mason

18 BIRTHPLACE OF FATHER (City) Russia (State or country)

19 MAIDEN NAME OF MOTHER Bertha Shirley

20 BIRTHPLACE OF MOTHER (City) Russia (State or country)

21 Informant Mary F. Sreehen (Address) Hathorne, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED January 17, 1963



FEB - 61963 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

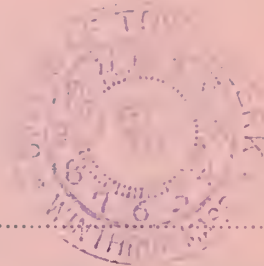
RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

RECEIVED



SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE FEB - 6 1963 AM
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 17

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Martin F. Slattery (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) W.W.T.

(a) Residence. No. 155 River Rd. St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 12 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Nov. 1952 to JAN. 12, 1963.
I last saw him alive on JAN. 11, 1963, death is said to
have occurred on the date stated above, at 3:23 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage 18 hrs.

Due To (b) Cerebral Arteriosclerosis 1 yr.

Due To (c)

OTHER SIGNIFICANT CONDITIONS Pulmonary Emphysema 15 yrs.
Coronary Artery Disease 1 yr.

Was autopsy performed?

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signature) Charles Liberman M. D.

(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date Jan. 12, 1963

6 Hand in Hand West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 13, 1963

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 120 Harvard Street, Brookline.

Received and filed JAN 14 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED WIDOWED
DIVORCED DIVORCED
UNKNOWN UNKNOWN

11 If married, widowed, or divorced, Miriam Hambro
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 68 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Accountant (retired)
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. 020-14-4350

16 BIRTHPLACE (City) Framingham, Mass.
(State or country)

17 NAME OF FATHER Edward Slattery

18 BIRTHPLACE OF FATHER (City) Massachusetts
(State or country)

19 MAIDEN NAME OF MOTHER Mary Sahey

20 BIRTHPLACE OF MOTHER (City) Boston, Mass.
(State or country)

21 Informant Miriam Slattery
(Address) 155 River Road, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) Jan 12, 1963

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

11-26-1917

9-30-1921

JAN 14 1963 AM

Yeoman 1st Class

U.S. Navy

NONE

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

1

PLACE OF DEATH

Essex
(County)

Danvers
(City or Town)

Danvers State Hospital, Hathorne St.

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 8

2 FULL NAME Frank P. Hallett
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(a) Residence. No. 58 Otis St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)
Length of stay: In place of death 5 years 12 months 12 days. In place of residence 5 years 12 months 12 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 18, 1963
(Month) (Day) (Year)
4 I HEREBY CERTIFY, That I attended deceased from August 6, 62 to January 18, 63
I last saw him alive on January 18, 1963, death is said to have occurred on the date stated above, at 8:45a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) General Arteriosclerosis

Due To Arteriosclerotic heart disease
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Willard M. Hausman, M. D.
(Address) Hathorne, Mass. Date 1/22/1963

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 23, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS Winthrop, Mass.

Received and filed FEB 6 1963 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED married

10a If married, widowed, or divorced
HUSBAND of Unknown
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 3 Months 17 Days
If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Fruit & Produce (Wholesale)
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 022-05-6726

16 BIRTHPLACE (City) Everett
(State or country) Mass.

17 NAME OF FATHER Warren Hallett

18 BIRTHPLACE OF FATHER (City) Cape Cod
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Nellie Burse

20 BIRTHPLACE OF MOTHER (City) Salem,
(State or country) Mass.

21 Informant Mary E. Sheehan
(Address) Hathorne, Mass.

A TRUE COPY

ATTEST: Paul J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED January 25, 1963

10-10-63

VIA ✓



FEB - 61963 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

for burial permit
ard of Health
ts Agent.

INSTRUCTIONS
FOR
L CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return,

STANDARD
CERTIFICATE OF DEATH

Registered No. 9

PLACE OF DEATH

DORFOLK
(County)WINTHROP
(City or Town)

No. WINTHROP COM. HOSP

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME DOROTHEA (TAUCHEN) SAFFORD
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, NO
if so specify WAR)(a) Residence, No. 94 LOCUST ST
(Usual place of abode)St. WINTHROP
(City or town and State)

Length of stay: In place of death, years months 7 days. In place of residence 44 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 18, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
June 1958, to January 18, 1963.I last saw her live on Jan. 18, 1963 death is said to
have occurred on the date stated above, at 1:08 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute left ventricular
dilatation

(b) Myocardial heart disease

(c) Rheumatic heart disease

OTHER SIGNIFICANT CONDITIONS pneumonia, hepato-
megaly with jaundiceINTERVAL
BETWEEN
ONSET AND
DEATH

minutes

yrs.
yrs.4-5
days

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorie, M.D.

(Print or Type Name)

(Address) 194 Washington Date Jan. 18, 1963

Wintthrop, Mass.

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 21 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed JAN 21 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

FEMALE WHITE MARRIED
WIDOWED
DIVORCED
UNKNOWN DIVORCED

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 44 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: CLERK
(Kind of work done during most of working life)

14 Industry or Business: BEVERAGE CO.

15 Social Security No. 010-03-0444
16 BIRTHPLACE (City) SOUTH BOSTON
(State or country) MASS

17 NAME OF FATHER JAMES TAUCHEN

18 BIRTHPLACE OF FATHER (City) AUSTRIA
(State or country)

19 MAIDEN NAME OF MOTHER ANNA M LSKA

20 BIRTHPLACE OF MOTHER (City) SOUTH BOSTON
(State or country) MASS

21 Informant MRS ANNA M. TAUCHEN

(Address) 94 LOCUST ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

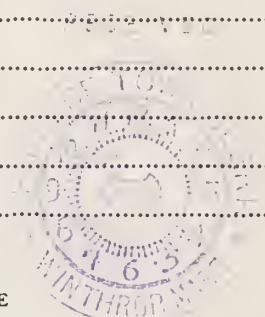
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only ~~all those of persons~~ to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

1

Essex
(County)
Danvers
(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 10

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Michael Eruzione
(If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, No

(a) Residence, No. 274 Bowdoin St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 11 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 22, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from January 11 1963 to January 22, 1963
I last saw him alive on January 22, 1963 death is said to have occurred on the date stated above, at 9:10p.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Arteriosclerotic heart disease years

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Bronchopneumonia days

Was autopsy performed? no
What test confirmed diagnosis? clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Willard M. Hausman, M. D.
(Address) Hathorne, Mass. 1/22/ 63

6 Holy Cross Cemetery, Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 26, 1963

7 NAME OF FUNERAL DIRECTOR Vincent Rapino
ADDRESS F. Boston, Mass.

Received and filed FEB 6 1963 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED widowed

10a If married, widowed, or divorced HUSBAND of Concetta Crissi
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 7 Months 8 Days If under 24 hours Hours Minutes

13 Usual Occupation: Laundry Worker
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 029-10-7001

16 BIRTHPLACE (City) Naples Italy
(State or country)

17 NAME OF FATHER Vincent Eruzione

18 BIRTHPLACE OF FATHER (City) Unknown
(State or country) Italy

19 MAIDEN NAME OF MOTHER Marie, maiden name unk

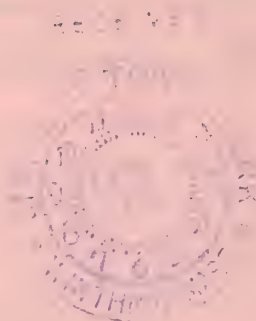
20 BIRTHPLACE OF MOTHER (City) Unknown
(State or country) Italy

21 Informant Mary E. Sheehan
(Address) Hathorne, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED January 25, 1963



SPACE FOR ADDITIONAL INFORMATION FEB - 61983 AM
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

Health Officer Jan 25, 1963
(Official Designation) (Date of Issue of Permit)

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including ~~falling~~ ^{driving} ~~stomachs~~), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

for burial permit
ard of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
a the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Jeanette Loessl Johnston

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. P20 - 3rd Floor Fort Banks

(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. 3 days. In place of residence. 4 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 1 25 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1963, to Jan 25, 1963

I last saw h. alive on Jan 25, 1963, death is said to have occurred on the date stated above, at 10:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary embolism

Due To Rheumatic heart disease

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Subacute Bacterial Endocarditis Cerebral embolism

Was autopsy performed? NO

What test confirmed diagnosis? Ecg X-Rays Blood studies

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) H. S. Greenfield, M. D.

(Print or Type Name)

(Address) 447 Shirley St. Date 1-26-63

6 Forest Hills Crematory Foston

Place of Burial or Cremation (City or Town) MASS.

DATE OF BURIAL January 28, 1963

7 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons

ADDRESS Foston, Mass.

Received and filed JAN 28 1963

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 12

(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Charles M. Johnston (Husband's name in full)

12 AGE 46 years 5 months 24 days If under 24 hours Hours Minutes

13 Usual Occupation Librarian (Kind of work done during most working life)

14 Industry or Business Fort Banks, Winthrop, Mass.

15 Social Security No. 156-10-5917

16 BIRTHPLACE (City) Boston (State or country) Mass.

17 NAME OF FATHER Cannot be learned Loessl

18 BIRTHPLACE OF FATHER (City) Munich (State or country) Germany

19 MAIDEN NAME OF MOTHER Fertha Petrol

20 BIRTHPLACE OF MOTHER Sulself (State or country) Germany

21 Informant Charles Snyder

(Address) 10 Riverdale Rd., Concord, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

2 NAME OF FETUS Baby Boy Miller
(if given)3 DATE OF DELIVERY 1 26 1963
(Month) (Day) (Year)

Registered No.

13

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)4 SEX Male ☒ Female ☐ Undetermined ☐

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single ☒ Twin ☐ Triplet ☐7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd8 FULL NAME
FATHER Herbert Miller14 MAIDEN NAME Teresa Joyce
PRESENT NAME Teresa Miller9 RESIDENCE, NO. 192 Constitution Ave STREET
CITY OR TOWN Revere STATE Mass.15 RESIDENCE, NO. 192 Constitution Ave STREET
CITY OR TOWN Revere STATE Mass.

10 COLOR OR RACE Wh. 11 AGE AT TIME OF THIS DELIVERY 38 (Years)

16 COLOR OR RACE Wh 17 AGE AT TIME OF THIS DELIVERY 32 (Years)

12 PLACE OF BIRTH Chelsea Mass.
(City or Town) (State or country)18 PLACE OF BIRTH Roxbury Mass.
(City or Town) (State or country)

13 OCCUPATION Laborer

19 INFORMANT Herbert Miller

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus) 2

(a) How many children are now living? 2

(b) How many children were born alive but are now dead? 0

(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY 8 1/2 completed weeks

22 WEIGHT OF FETUS 7 Lb 15 Oz
(or Grams)23 WHEN DID FETUS DIE? Before Labor ☒ During Labor ☐ or Delivery ☐ Unknown ☐24 AUTOPSY Yes ☐ No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Unknown

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 Holy Cross Cem. Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 28 196327 NAME OF FUNERAL DIRECTOR Paul Buonfiglio
ADDRESS 128 Revere St Revere

Received and filed

JAN 29 1963

19

Registrar

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF FETAL DEATH
(STILLBIRTH)To be filed for burial permit with
Board of Health or its Agent.In giving
CAUSE OF
FETAL DEATHdo not enter
more than one
cause for each
of (a), (b)
and (c)tal or maternal
condition causing
fetal death (do
not use such
terms as stillbirth
prematurity.)tal and/or mal-
nial conditions,
any, which gave
rise to above
use (a), stating
the underlying
cause last. →→
conditions of fetus
mother which
may have contrib-
uted to fetal
death, but, in so
far as is known,
are not related
to cause given
(a).I HEREBY CERTIFY that this delivery occurred on the date stated
above at 4:12 A.M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Myron N. King M.D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)Address 222 PLEASANT ST Date 1/28 1963
WINTHROP ST, MASSI HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sirianian
(Signature of Agent of Board of Health or other)Health Officer Jan 28 - 1963
(Official Designation) (Date of Issue of Permit)

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

not enter
ce than one
se for each
, (b) and (c)

does not mean
ode of dying,
s heart failure,
etc. It means
case, or compli-
which caused

itions, if any,
gave rise to
cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

c.

PLACE OF DEATH

1

Suffolk
(County)
Weymouth
(City or Town)

No. *56 Chester St. Ave*

2 FULL NAME

Harry London

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

56 Chester Ave

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death *9* years *—* months *—* days. In place of residence *9* years *—* months *—* days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

*JAN**27**1963*

(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from *MAY 14* *57* to *JAN 27* *1963*I last saw him live on *JAN 27* *1963* death is said to have occurred on the date stated above, at *12:30* p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *ACUTE MYOCARDIAL INFARCTION 15MIN*

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

*NONE*Was autopsy performed? *No*What test confirmed diagnosis? *CLINICAL*5 Was disease or injury in any way related to occupation of deceased? *No*

If so, specify

Signature) *Myran N. King*, M. D.*MYRAN N. KING M.D.*

(Print or Type Name)

(Address)

200 Pleasant St.

Date

*1/27**1963*6 *Community Soc. Millers*

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Jan 28

7 NAME OF FUNERAL DIRECTOR

Joseph A. Audac

ADDRESS

Chelsea

Received and filed

JAN 28 1963

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. *14*

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

*Male**White**MARRIED**Married*

11 If married, widowed, or divorced

HUSBAND of

Emmy Eisenberg

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE

51 Years *—* Months *—* Days

If under 24 hours

— Hours *—* Minutes

13 Usual

Occupation

Supermarket

(Kind of work done during most working life)

14 Industry

or Business

N.E. Nuclear Corp.

15 Social Security No.

013-05-1940

16 BIRTHPLACE (City)

(State or country)

Boston Mass

17 NAME OF

FATHER

Morris London

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Russia

19 MAIDEN NAME

OF MOTHER

Rose Mirchels

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Russia

21 Informant

(Address)

*Emmy London**56 Chester St. Weymouth*

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Emmy London

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

Jan 27 1963

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

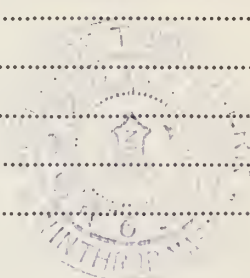
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JAN 28 1963 PM

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

:- Chapter 137,
of 1954, requires
cians to print or
the cause or
a of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

PLACE OF DEATH

1

Suffolk

(County)

Winthron

(City or Town)

No. Bay View Nursing Home

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 15

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
{ U. S. War Veteran, no
{ if so specify WAR)

2 FULL NAME Sophia Rosenauer
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 5 Common Street St. Quincy, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 27 63
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan 21 63, to Jan 27 63
I last saw her alive on Jan 27 63, death is said to
have occurred on the date stated above, at 12:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cerebral thrombosis

Due To (b) arteriosclerosis 7 days
Due To (c) Senility

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signed) H. B. Greenfield, M. D.
(PRINT OR TYPE SIGNATURE)
(Address) 447 Shirley Mass. Date 1-27 1963

6 Knights of Liberty, Woburn (Montvale)
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 29, 1963

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline.

Received and filed JAN 28 1963 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED Widowed

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Alexander Rosenauer
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 90 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: none

15 Social Security No. none

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Hyman Sansiper

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Anna Levine

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Miss Dorothy Rosenauer
(Address) 5 Common St., Quincy, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer Jan 28 1963
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

JAN 28 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Mayflower Nursing Home

STANDARD
CERTIFICATE OF DEATH

Registered No. 16

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

2 FULL NAME. Helen (Huse) Smith

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 10 Wave Way Ave.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death. 17 years. months. days. In place of residence. 1 years. months. days.

INSTRUCTIONS
FOR
CERTIFICATE

a giving
OF DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

Chapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates, and
48, Acts of
requires Physi-
to print or type
under signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 27, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Nov., 1961, to Jan. 27, 1963

I last saw her alive on Jan. 26, 1963, death is said to
have occurred on the date stated above, at 2:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

Due To (b) Hypertension

Due To (c)

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M.D.

CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP Date 1/28/1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 27, 1963

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed JAN 29 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED Widow

10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)
(or) WIFE of Benjamin D. Smith
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 6 Months 23 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Boston
(State or country) Mass.

17 NAME OF FATHER George Huse

18 BIRTHPLACE OF FATHER (City) Maine
(State or country)

19 MAIDEN NAME OF MOTHER Eliza Dwyer

20 BIRTHPLACE OF MOTHER (City) Maine
(State or country)

21 Informant William H. Smith
(Address) Ashland, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
OF DEATH

not enter
more than one
cause for each
(a), (b) and (c)

does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
which caused

conditions, if any,
which gave rise to
the cause (a),
the under-
cause last.

conditions contrib-
to death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 17

No. Mayflower Nursing Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Henry Arthur Cutting
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 52 Bellevue Avenue Winthrop, Mass.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 8 years months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 28 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Jan. 1963 to Jan. 26 1963
I last saw him alive on Jan. 7 1963 death is said to
have occurred on the date stated above, at 11:41 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart *yo*
Due To *yo*
(b) arteriosclerosis *yo*
Due To *yo*
(c) Senility *yo*

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER SIGNIFICANT CONDITIONS
Parkinson's disease *yo*

Was autopsy performed? *yo*
What test confirmed diagnosis? *yo*

5 Was disease or injury in any way related to occupation of deceased? *yo*
If so, specify

(Signature) Joseph B. Marsh, M. D.
(Print or Type Name)
(Address) 194 Washington St. Date 1/28/63

Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 29, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JAN 29 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) married
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Grace Vivien Dodge
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 79 Years 1 Months 29 Days If under 24 hours
Hours Minutes

13 Usual Occupation retired fireman
(Kind of work done during most working life)

14 Industry
City of Business Cambridge Fire Dept.

15 Social Security No. none

16 BIRTHPLACE (City) Cambridge Mass.
(State or country)

17 NAME OF FATHER Charles Henry Cutting

18 BIRTHPLACE OF FATHER (City) Charlestown Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Fannie Coleman

20 BIRTHPLACE OF MOTHER (City) Cambridge Mass.
(State or country)

21 Informant Grace D. Cutting
(Address) 52 Bellevue Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) Jan. 29, 1963

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

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(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
L CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
se for each
, (b) and (c)

does not mean
ode of dying,
heart failure,
etc. It means
case, or compli-
which caused

tions, if any,
gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
o death but not
to the terminal
condition given

PLACE OF DEATH

SUFFOLK

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

18

2 FULL NAME Ruggiero, Baby Girl

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, **no**
if so specify WAR)

(a) Residence. No. 2 St. Andrew Rd. E. Boston

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 30 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from 1-30, 1963, to 1-30, 1963

I last saw her alive on 1-30, 1963, death is said to

have occurred on the date stated above, at 5:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ANXIA

INTERVAL
BETWEEN
ONSET AND
DEATH

1 hr 5 min

Due To Pulmonary Atelectasis

(b)

Due To PREMATUREITY

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Jacob B. Burke, M. D.

(Print or Type Name)

(Address) 42 CRESCENT ST Date 1-30 1963

CHelsea

6 Holy Cross Cemetery Malden

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Feb. 2, 1963

7 NAME OF FUNERAL DIRECTOR Vincent Kapino

ADDRESS 9 Chelsea St. East Boston, Mass.

Received and filed 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR white 10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE.....Years.....Months.....Days 14 under 24 hours

Hours 5 Minutes

13 Usual Occupation: none

(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. none

16 BIRTHPLACE (City) Winthrop, Mass.
(State or country)

17 NAME OF FATHER Joseph Ruggiero

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Josephine Pignato

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.21 Informant Joseph Ruggiero (father)
(Address) 2 St. Andrew Rd., East Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

FEB 1 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

d for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
e for each
(b) and (c)

Does not mean
de of dying,
heart failure,
etc. It means
cause, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
o the terminal
condition given

te: - Chapter 137,
of 1954 requires
icians to print or
the cause or
es of death on
certificates, and
ter 48, Acts of
requires Physi-
s to print or type
under signature.

icatti

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 19

PLACE OF DEATH
1 (County) *Wintthrop*
(City or Town)

No. *Wintthrop Four Nine*

(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

2 FULL NAME *Camille Colangelo*
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR,

(a) Residence, No. *1048 Rear Saratoga*
(Usual place of abode)

St. *EB.*
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....*3* months.....*4* days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *Jan 31 1963*
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Oct 2 1962 to *Jan 31 1963*
I last saw her alive on *Jan 30 1963*, death is said to
have occurred on the date stated above, at *6 p.m.*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Carcinoma Colon*

INTERVAL
BETWEEN
ONSET AND
DEATH

3 mos.

(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS *metastasis to Brain*

Was autopsy performed? *no*What test confirmed diagnosis? *-*

5 Was disease or injury in any way related to occupation of deceased?
If so, specify *no*

(Signed) *G. GUY GRANDE M.D.*, M. D.
(Print or Type Name)

20 SARATOGA ST. EAST BOSTON
(Address) (Date) *2-1 1963*

6 *St. Cross Cemetery Malden*
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *Feb 4 1963*

7 NAME OF FUNERAL DIRECTOR *John Guisti Sons*

ADDRESS *7 Cooper St. Boston*

Received and filed *FEB 4 1963*

(Registrar of City or Town where deceased resided)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *Female* 9 COLOR *White* 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of *FRANCISCO COLANGELO*
(Husband's name in full)

12 AGE *80* Years *3* Months *3* Days If under 24 hours
Hours *0* Minutes

13 Usual Occupation *None*
(Kind of work done during most working life)

14 Industry or Business *None*

15 Social Security No. *None*

16 BIRTHPLACE (City) *Italy*
(State or country)

17 NAME OF FATHER *Giuseppe Di Santo*

18 BIRTHPLACE OF FATHER (City) *Italy*
(State or country)

19 MAIDEN NAME OF MOTHER *Lucia*

20 BIRTHPLACE OF MOTHER (City) *Italy*
(State or country)

21 Informant *Joseph Colangelo*
(Address) *1048 Saratoga St. EB.*

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Guarnieri
(Signature of Agent of Board of Health or other)
Health Officer (Official Designation) *Feb 1 1963* (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FEB - 4 1963 PM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M.3-61-930213

PLACE OF DEATH

Essex
(County)Danvers
(City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCOPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Danvers

(City or town making return)

Registered No.

20

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Ann Davis (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 398 Grovers Avenue St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death... 0 years... 2 months... 3 days. In place of residence... years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 31, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fracture Rt. Hip
Bronchopneumonia

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury Oct. 31, 1963

If accidental, was injury causally related to the death? yes

Where did injury occur? Winthrop, Mass.
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public place? Nursing Home
(Specify type of place)Manner of injury Fell to floor
(How did injury occur?)

Nature of injury as above

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased no

If so, specify Ralph P. McCarthy
(Signed) Ralph P. McCarthy M. D.
(Address) Peabody, Mass. Date 2/1/19637 St. Joseph's Cemetery, Roxbury
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL February 5, 1963

8 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS East Boston, Mass.

Received and filed February 6, 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN
female	white	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

12a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH March 28, 1876

14 AGE 86 Years 10 Months 3 Days If under 24 hours Hours Minutes

15 Usual Occupation: Proof Reader
(Kind of work done during most of working life)

16 Industry or Business:

17 Social Security No. Not Determined

18 BIRTHPLACE (City) Boston
(State or country) Mass.

19 NAME OF FATHER Joseph H. Davis

20 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

21 MAIDEN NAME OF MOTHER Mary Baker

22 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)23 Informant Mary E. Sheehan
(Address) Hathorne, Mass.A TRUE COPY.
ATTEST: Donnell Toomey
(Registrar of City or Town where death occurred)

DATE FILED February 5, 1963



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE FEB - 1963 AM

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

The Commonwealth of Massachusetts

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Brockton

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 21

Veterans Administration Hospital

No. _____ Date of death occurred in a hospital or institution,
 St. (give its NAME instead of street and number)

John E. Downey

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
 U. S. War Veteran,
 if so specify WAR,

WW I

(a) Residence, No.

(Usual place of abode)

141 Brook

St.

(Brighton) Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death, 8 years, 0 months, 22 days. In place of residence, 59 years, 2 months, 8 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

January 14, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That deceased died on

August 2, 1959, at 3:55 PM, in the City of Brockton, Massachusetts.

I last saw him alive on August 2, 1959, at 3:55 PM, in the City of Brockton, Massachusetts.

have occurred on the date stated above, at 3:55 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarct.

(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Leo Waitzkin, M. D.

VA Hosp.

Brockton, Mass. 1/15/63

(Address) _____ Date 19

Winthrop Cemetery, Winthrop, Mass.

6 Place of Burial or Cremation January 17, 1963

DATE OF BURIAL _____ 19

7 NAME OF FUNERAL DIRECTOR John E. McKvoy

225 Mass. Ave., Arlington, Mass.

ADDRESS _____

Received and filed FEB 15 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

white

10 SINGLE (write the word)

MARRIED married

WIDOWED

DIVORCED

UNKNOWN

11 If married, widowed or divorced

HUSBAND of Helen E. Grant

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE 67 2 28

Years Months Days

If under 24 hours

Hours Minutes

13 Usual Occupation:

Electrician

(Kind of work done during most working life)

14 Industry or Business:

Electrical

unknown

15 Social Security No.

East Boston

16 BIRTHPLACE (City) Massachusetts

(State or country)

17 NAME OF FATHER

John F. Downey

18 BIRTHPLACE OF FATHER (City)

Charlestown

(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER

Catherine A. Keough

20 BIRTHPLACE OF MOTHER (City)

Revere

(State or country) Massachusetts

21 Informant (Address)

VA Hospital Records

Brockton, Massachusetts

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

Jan. 15

63

(Registrar of City or Town where deceased resided)

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON - THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE..... July 14, 1916
DATE OF DISCHARGE..... April 28, 1919
RANK, RATING..... Corporal
ORGANIZATION AND OUTFIT..... U. S. Army
SERVICE NUMBER..... 62 608
.....

FEB 15 1963 AM

Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
case, or compli-
which caused

itions, if any,
gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
to death but not
to the terminal
condition given

ic

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 22

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Gladstone
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 24 Hawthorne Avenue St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 1 days. In place of residence 13 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 4 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 1961 to FEB 4 1963

I last saw him alive on FEB 4 1963, death is said to have occurred on the date stated above, at 10:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION 8 HRS.

(b) Due To ARTERIO-SCLEROTIC HEART DISEASE 1 YRS.

(c) Due To

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 212 Pleasant St. Date 2/4 1963

6 Place of Burial or Cremation Winthrop, Mass.
(City or Town)

DATE OF BURIAL Feb 5 1963

7 NAME OF FUNERAL DIRECTOR J. J. Farnsworth Inc.

ADDRESS Chelsea

Received and filed FEB 5 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed Divorced UNKNOWN Married

11 If married, widowed or divorced HUSBAND of Cora Goodfield
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 57 Years 5 Months 5 Days If under 24 hours Hours Minutes

13 Usual Occupation Proprietor
(Kind of work done during most working life)

14 Industry or Business Gasoline Station

15 Social Security No.

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER (E. B. L.) Gladstone

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER E. B. L.

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Gordon Gladstone
(Address) 26 Belmont St. N. Roxbury

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Joseph E. Lirianne
(Signature of Agent of Board of Health or other)

Health Officer Feb 5 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

FEB - 5 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
o the terminal
condition given

X
PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 23

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Joseph Porcella
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence, No. 132 Crest Avenue
(Usual place of abode)

St. Revere Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death years months 15 days. In place of residence 55 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 5, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb. 1, 1963, to Feb. 5, 1963,

I last saw him alive on Feb. 5, 1963, death is said to
have occurred on the date stated above, at 7:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Adenocarcinoma of Colon 1 month
Resection of Bowel 1/31/63

Was autopsy performed? No

What test confirmed diagnosis? Pathological Examination
of specimen and EKG

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) John F. Collins M.D.

John F. Collins, M.D.

(Print or Type Name)

(Address) 27 Bennington St. Date Feb. 6, 1963

6 Burial Lawn Peabody
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 2/8/63

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave. Revere

Received and filed FEB 6 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed

11 If married, widowed, or divorced
HUSBAND of Louise F. Bravara
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 84 Years Months 25 Days If under 24 hours
Hours Minutes

13 Usual Occupation Retired - Lawyer
(Kind of work done during most working life)

14 Industry or Business

15 Social Security No. 012-16-4688

16 BIRTHPLACE (City) Boston
(State or country) Mass

17 NAME OF FATHER Stephen Porcella

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER ANNA Ansaldo

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Mrs. Beatrice Collins
(Address)

134 Crest Ave. Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Scranne
(Signature of Agent of Board of Health or other)

Health Officer
(Official Designation)

Feb 6 1963
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FEB - 6 1963 CH

M R-303

for burial permit
Board of Health
its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, (U.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

X
PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

Bay View Nursing Home

No. 41 Washington Avenue, Winthrop

2 FULL NAME

JOHANNA

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

GALLAGHER

Registered No.

24

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
{ U. S. War Veteran,
{ if so specify WAR)

no

(a) Residence, No.

31 Palmyra St., Winthrop

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 4 years.....months.....days. In place of residence 28 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

February

6,

1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic heart disease.

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?

(Specify type of place)

Manner of

Injury

(How did injury occur?)

Nature of

Injury

While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation or deceased?

If so, specify

(Signature) *Michael A. Luongo* M. D.

Michael A. Luongo, M.D.

(Print or Type Name)

(Address) Boston

Date 2/7

19 63

7 Winthrop Cemetery

Winthrop

Place of Burial, or Cremation.

(City or Town)

DATE OF BURIAL

February 9

19 63

8 NAME OF

FUNERAL DIRECTOR

Arthur J. O'Maley

ADDRESS

Winthrop Mass

Received and filed

FEB 7 1963

19.....

A TRUE COPY ATTEST:

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S

CERTIFICATE OF DEATH

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

GALLAGHER

(Last Name)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 4 years.....months.....days. In place of residence 28 years.....months.....days.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

Female

10 COLOR

White

11 SINGLE (write the word)

MARRIED Widowed

WIDOWED

DIVORCED

UNKNOWN

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Daniel Gallagher

(Husband's name in full)

13 DATE OF BIRTH

Sept 21, 1878

14

AGE

85

Years.....

Months.....

Days

If under 24 hours

.....Hours

.....Minutes

15 Usual

Occupation

Housewife

(Kind of work done during most of working life)

16 Industry

or Business

Own Home

17 Social Security No.

None

18 BIRTHPLACE (City)

Hoboken

(State or country)

New Jersey

19 NAME OF

FATHER

Michael Murphy

20 BIRTHPLACE OF

FATHER (City)

Ireland

(State or country)

21 MAIDEN NAME

OF MOTHER

Mary Carmody

22 BIRTHPLACE OF

MOTHER (City)

Ireland

(State or country)

23

Informant

(Address)

Lillian Abbott

31 Palmyra St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lynam
(Signature of Agent of Board of Health or other)

(Official Designation)

Feb. 7 1963

(Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

RULES OF PRACTICE

FEB - 7 1963 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

for burial permit
ard of Health's Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 25

PLACE OF DEATH

Suffolk
Winthrop
(County)
(City or Town)



Mount's Convalescent Home

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James D. Hoy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) No.

(a) Residence. No. 10 Lexington St. Ave. E. Boston
(Usual place of abode) (City or town and State)

Length of stay: In place of death. 6 months. days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 6, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
May 20, 1962, to Feb 7, 1963.
I last saw him alive on Jan 20, 1963, death is said to
have occurred on the date stated above, at 6:15 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

(b) Generalized Arteriosclerosis

(c) Hypertension

OTHER SIGNIFICANT CONDITIONS: Diabetic Mellitus

Was autopsy performed? no
What test confirmed diagnosis? Clinical Exam

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Louis E. Schreffler, M. D.

(Address) 19 Bennington St. E.B. Date 2-7-1963

Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb 9, 1963

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS East Boston

Received and filed FEB 8 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed or divorced
HUSBAND of MARGARET NEWBORN
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 76 Years. Months. Days If under 24 hours
Hours. Minutes

13 Usual Occupation Custodian
(Kind of work done during most of working life)

14 Industry or Business U.S. Postal Service Ret.

15 Social Security No.

16 BIRTHPLACE (City) BOSTON MASS
(State or country)

17 NAME OF FATHER DANIEL HOY

18 BIRTHPLACE OF FATHER (City) LYNN
(State or country) MASS.

19 MAIDEN NAME OF MOTHER ANNIE KENNEDY

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS

21 Informant MARGARET HOY

(Address) 10 Lexington Ave. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

FEB - 8 1963 FM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

oes not mean
le of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 26

PLACE OF DEATH

1

2

(a)

Length of stay:

3

4

DEATH WAS CAUSED BY:

(a)

Due To

Due To

OTHER

Was autopsy performed?

What test confirmed diagnosis?

5

(Signature)

(Address)

6

DATE OF BURIAL

7

ADDRESS

Received and filed

A TRUE COPY ATTEST:



Suffolk
(County)
Winthrop
(City or Town)

No.

FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

3

4

DEATH WAS CAUSED BY:

(a)

Due To

Due To

OTHER

Was autopsy performed?

What test confirmed diagnosis?

5

(Signature)

(Address)

6

DATE OF BURIAL

7

ADDRESS

Received and filed

A TRUE COPY ATTEST:

No.

FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

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DEATH WAS CAUSED BY:

(a)

Due To

Due To

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Was autopsy performed?

What test confirmed diagnosis?

5

(Signature)

(Address)

6

DATE OF BURIAL

7

ADDRESS

Received and filed

A TRUE COPY ATTEST:

No.

FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

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DEATH WAS CAUSED BY:

(a)

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What test confirmed diagnosis?

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(Signature)

(Address)

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DATE OF BURIAL

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ADDRESS

Received and filed

A TRUE COPY ATTEST:

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FULL NAME

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(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

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(Signature)

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A TRUE COPY ATTEST:

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FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

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(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

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DEATH WAS CAUSED BY:

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What test confirmed diagnosis?

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(Signature)

(Address)

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FULL NAME

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(Usual place of abode)

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Due To

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What test confirmed diagnosis?

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(Signature)

(Address)

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DATE OF BURIAL

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ADDRESS

Received and filed

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FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

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DEATH WAS CAUSED BY:

(a)

Due To

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What test confirmed diagnosis?

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(Signature)

(Address)

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DATE OF BURIAL

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ADDRESS

Received and filed

A TRUE COPY ATTEST:

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FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

3

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DEATH WAS CAUSED BY:

(a)

Due To

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Was autopsy performed?

What test confirmed diagnosis?

5

(Signature)

(Address)

6

DATE OF BURIAL

7

ADDRESS

Received and filed

A TRUE COPY ATTEST:

No.

FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

3

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DEATH WAS CAUSED BY:

(a)

Due To

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What test confirmed diagnosis?

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(Signature)

(Address)

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DATE OF BURIAL

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ADDRESS

Received and filed

A TRUE COPY ATTEST:

No.

FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

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DEATH WAS CAUSED BY:

(a)

Due To

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What test confirmed diagnosis?

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(Signature)

(Address)

6

DATE OF BURIAL

7

ADDRESS

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A TRUE COPY ATTEST:

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FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

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DEATH WAS CAUSED BY:

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Due To

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What test confirmed diagnosis?

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(Signature)

(Address)

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ADDRESS

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FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

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Due To

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What test confirmed diagnosis?

5

(Signature)

(Address)

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DATE OF BURIAL

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Received and filed

A TRUE COPY ATTEST:

No.

FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

3

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DEATH WAS CAUSED BY:

(a)

Due To

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What test confirmed diagnosis?

5

(Signature)

(Address)

6

DATE OF BURIAL

7

ADDRESS

Received and filed

A TRUE COPY ATTEST:

No.

FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a)

(Usual place of abode)

MEDICAL CERTIFICATE OF DEATH

3

4

DEATH WAS CAUSED BY:

(a)

Due To

Due To

OTHER

Was autopsy performed?

What test confirmed diagnosis?

5

(Signature)

(Address)

6

DATE OF

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.



SUFFOLK

(County)

WINTHROP

(City or Town)

CERTIFICATE OF DEATH

Registered No.

27

No. MOUNTS REST HOME CONVALESCENT (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ADELAIDE E. COLEMAN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 69 JOHNSON AVE

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death years months 14 days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 12 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1962, to February 12, 1963

I last saw her alive on Feb. 11, 1963, death is said to

have occurred on the date stated above, at 6:45 A.M.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerosis cerebral

4 wks.

Due To (h) Arteriosclerosis, generalized

5 yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus

10 yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) CHARLES LIBERMAN, M. D.

(Address) WINTHROP, MASS Date 2/12/1962

6 ST BRIDGETS AMHERST MASS

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL FEB 14 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed FEB 13 1963

19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED SINGLE

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation CLERK (Retired)

(Kind of work done during most of working life)

14 Industry or Business: MACHINERY MFG.

15 Social Security No. 019-03-8534

16 BIRTHPLACE (City) AMHERST MASS

17 NAME OF FATHER MATHEW COLEMAN

18 BIRTHPLACE OF FATHER (City) IRELAND (State or country)

19 MAIDEN NAME OF MOTHER ANNE GLEASON

20 BIRTHPLACE OF MOTHER (City) IRELAND (State or country)

21 Informant AGUSTINE CAMONDO (Address) 69 JOHNSON AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer

FEB 13 1963

(Official Designation)

(Date of Issue of Permit)

T V

EXTRACTS
FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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than one
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etc. It means
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 28

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 19 CORAL Ave

2 FULL NAME JACOB MILLER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)

(a) Residence. No. 19 CORAL Ave
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 8 years months days. In place of residence 8 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 15 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19 to 19

I last saw h alive on 19 death is said to
have occurred on the date stated above, at 1:25 am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death occurred at 1:25 AM

Due To (b) on Feb 15, 1963 Death apparently

Due To (c) due to natural causes, presumably
acute coronary occlusion based

OTHER SIGNIFICANT CONDITIONS on history and medical records

Was autopsy performed? Winthrop Board of Health

What test confirmed diagnosis Charles Lieberman, M.D.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Lieberman, M. D.

CHARLES LIEBERMAN
(Print or Type Name)

(Address) WINTHROP MASS Date 2/15/1963

6 MONTIFLORE Soc. EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 17 1963

7 NAME OF FUNERAL DIRECTOR TORI Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed FEB 18 1963

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of SARAH GOLDMAN
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 52 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation CLERK
(Kind of work done during most working life)

14 Industry or Business RETAIL FOODS

15 Social Security No. 034-03-8103

16 BIRTHPLACE (City) MALDEN MASS
(State or country)

17 NAME OF FATHER DAVID MILLER

18 BIRTHPLACE OF FATHER (City) RUSSIA
(State or country)

19 MAIDEN NAME OF MOTHER BESSIE MILLER (OK)

20 BIRTHPLACE OF MOTHER (City) RUSSIA
(State or country)

21 Informant SARAH MILLER
(Address) 19 CORAL Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lizzanne
(Signature of Agent of Board of Health or other)

Health Officer Feb 15, 1963

(Official Designation) (Date of Issue of Permit)

TV

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

FEB 18 1963 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
Agent.

CTIONS
FOR
CERTIFICATE

OR TYPE
CAUSES
DEATH

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heart failure,
etc. It means
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the terminal
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2.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)



1

Winthrop
(City or Town)

No. Robert Owen Richards

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

Registered No. 29

STANDARD CERTIFICATE OF DEATH

PHYSICIAN — IMPORTANT

2 FULL NAME 24 Quincy Avenue
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

(a) Residence, No. 24 Quincy Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, 39 years, 39 months, 39 days. In place of residence, 39 years, 39 months, 39 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 16 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
JANUARY 27 1963, to FEBRUARY 16 1963
I last saw him alive on FEBRUARY 15, 1963, death is said to
have occurred on the date stated above, at 2:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CEREBRAL HEMORRHAGE

Due To (b) ARTERIOSCLEROSIS

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Dorothy Cheney Appleton M. D.
DOROTHY CHENEY APPLETON
(Print or Type Name)

(Address) 197 Woodside Ave. Date 2/18 1963
Winthrop, Mass.

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 19 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. March

ADDRESS 174 Winthrop St. Winthrop

Received and filed FEB 19 1963 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED single
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 85 Years 1 Months 24 Days If under 24 hours
Hours Minutes

13 Usual Occupation (retired) Bldg. Supt.
(Kind of work done during most working life)

14 Industry or Business commercial apartments

15 Social Security No. 010-03-223 1793

16 BIRTHPLACE (City) England
(State or country)

17 NAME OF FATHER Edward Richards

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Jones

20 BIRTHPLACE OF MOTHER (City) Wales
(State or country)

Informant Alfred O. Richards
(Address) 24 Quincy Ave, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

~~FEB 1 1963~~ 8M
 RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but, also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
ard of Health
ts Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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than one
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to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 30

No. 10 Surfside Ave., Winthrop (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARY EMMA (Armstrong) TAYLOR (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 10 Surfside Avenue st. Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 40 years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEBRUARY 16, 1963 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

I last saw h.....alive on, 19....., death is said to have occurred on the date stated above, at 1:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death due to natural causes, presumably due to arteriosclerotic heart

OTHER SIGNIFICANT CONDITIONS disease

Was autopsy performed? Charles Liberman, M.D. What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles Liberman, M. D. CHARLES LIBERMAN (Print or Type Name)

(Address) Winthrop, Mass. Date 2/17/1963

6 Holy Cross Malden Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 19, 1963

7 NAME OF FUNERAL DIRECTOR FRANK H. CARR

ADDRESS 79 Elm St., Charlestown

Received and filed FEB 18 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Divorced UNKNOWN Married

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of FRANK L. TAYLOR (Husband's name in full)

12 AGE 92 Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: At Home

15 Social Security No.

16 BIRTHPLACE (City) Chester (State or country) Nova Scotia

17 NAME OF FATHER Robert Armstrong

18 BIRTHPLACE OF FATHER (City) Nova Scotia (State or country)

19 MAIDEN NAME OF MOTHER unknown

20 BIRTHPLACE OF MOTHER (City) Nova Scotia (State or country)

21 Informant Mrs. Esther Sanborn (Address) 32 Francis St., Belmont

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (Official Designation) (Date of Issue of Permit) Feb 18 1963

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FEB 18 1963 AM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
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death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 31

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. MAYFLOWER NURSING HOME 39 GROVER AVE (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JULIA J (BARRY) SULLIVAN
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, if so specify WAR) NO(a) Residence. No. 47 SONNYSIDE AVE
(Usual place of abode)St. WINTHROP
(City or town and State)

Length of stay: In place of death, years, months, days. In place of residence, 40 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 17 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Nov 62 to Feb 17 63
I last saw her alive on Feb 15 1963, death is said to
have occurred on the date stated above, at 7:10 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease
(b) Arteriosclerosis
(c) Diabetes MellitusINTERVAL
BETWEEN
ONSET AND
DEATH

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus 6 yrs

Was autopsy performed?
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Joseph E. Spigarelli, M. D.

(Print of Type Name) JOSEPH E. SPIGARELLI

(Address) 19 WINDHAM ST WINTHROP 2718 1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 20 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP

Received and filed FEB 19 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN WIDOWED11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of CORNELIUS SULLIVAN
(Husband's name in full)12 AGE 77 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business: HOME

15 Social Security No. NAME

16 BIRTHPLACE (City) IRELAND
(State or country)

17 NAME OF FATHER JOHN SULLIVAN BARRY

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant JOSEPH F. SULLIVAN

(Address) 47 SONNYSIDE AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (No)

Health Officer Feb 19 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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than one
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(b) and (c)

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heart failure,
etc. It means
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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 32

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Elizabeth McCluskey (Dunnigan)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) no

(a) Residence. No. 18 James Ave., Winthrop Mass

(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 16 days. In place of residence 38 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 18 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan. 1962 to Feb 18 1963

I last saw her alive on Feb. 18 1963 death is said to

have occurred on the date stated above, at 10:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive and Arterio- 3 yrs.

(b) Sclerotic Heart Disease

Due To
(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) Winthrop, Mass. Date 2/18/1963

6 St. Patrick's Lowell
(Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Feb. 21 1963

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS Winthrop

Received and filed FEB 19 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female	9 COLOR White	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
-----------------	------------------	---

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Frank A. McCluskey
(Husband's name in full)

12 AGE 81 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Domestic
(Kind of work done during most working life)

14 Industry or Business: House 027-28-4881

15 Social Security No. North Chelmsford

16 BIRTHPLACE (City) Mass.
(State or country)

17 NAME OF FATHER Francis Dunnigan

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary McArdle

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Mary McCluskey
(Address)

18 James Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... July 15, 1942

DATE OF DISCHARGE..... Feb. 24, 1945

RANK, RATING..... MoMM Second Class

ORGANIZATION AND OUTFIT..... U S Navy

SERVICE NUMBER..... 140-40-83

.....
RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

.....
Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

.....
Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FEB 25 1943 AM

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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condition given

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 34

PLACE OF DEATH

Suffolk
(County)
Winthrop

(City or Town)

No. 47 Washington Avenue

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

2 FULL NAME Jennie S. Roitman

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, no
if so specify WARI)

(a) Residence. No. 47 Washington Avenue
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 22, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at.....m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ~~Death due presumably to~~

Due To natural causes, probably

(b) acute coronary occlusion on
(c) basis of history

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health
Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles Liberman, M. D.

(Address) WINTHROP, MASS. Date: 2/22/1963
(Print or Type Name)

6 Forest Hills Crematory, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 25, 1963

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline

Received and filed FEB 25 1963 19

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female	9 COLOR white	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN married
--------------	---------------	---

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Abraham Roitman
(Husband's name in full)

12 AGE 77 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Physician (retired)
(Kind of work done during most working life)

14 Industry
or Business:

15 Social Security No.

16 BIRTHPLACE (City) Latvia
(State or country)

17 NAME OF FATHER Abraham Segal

18 BIRTHPLACE OF FATHER (City) Pussis
(State or country)

19 MAIDEN NAME OF MOTHER Treda (unknown)

20 BIRTHPLACE OF MOTHER (City) Pussis
(State or country)

21 Informant Abraham Roitman
(Address) 47 Washington Avenue, Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)
Health Officer Feb 25 1963
(Official Designation) (Date of Issue of Permit)

T V

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

FEB 25 1934

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
e, or compli-
which caused

ms, if any,
gave rise to
cause (a),
the under-
cause last.

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death but not
the terminal
condition given

c.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

Winthrop

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 35

No. Winthrop Com. Hosp

{ (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Rebecca G. Loebnerman

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{ (Was deceased a
U. S. War Veteran,
if so specify WAR) No

106 Summit Ave

(a) Residence. No.
(Usual place of abode)

St. Winthrop Mass

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 26 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 1950 to Feb 26 1963

I last saw her alive on Feb 26 1963, death is said to have occurred on the date stated above, at 6:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease

Due To (b) Myocardial Infarction

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 2/26/1963

6 TIFEREth Is. of Winthrop. Overth
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 27 1963

7 NAME OF FUNERAL DIRECTOR TOLF Funeral Service Inc

ADDRESS Washington Ave Chelsea

Received and filed FEB 27 1963 19

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEM 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

11 If married, widowed, or divorced HUSBAND of

(or) WIFE of BARNEY G. LOEBNERMAN
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 82 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Housewife
(Kind of work done during most working life)

14 Industry or Business AT Home

15 Social Security No. None

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER L. ABLE Sheets

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER C. B. L.

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Mrs Albert ARONOFESKY
(Address) 106 Summit Ave, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Liberman
(Signature of Agent of Board of Health or other)

Health Officer Feb 27 1963
(Official Designation) (Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

ons, if any,
e of dying,
heart failure,
etc. It means
se, or compli-
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gave rise to
cause (a),
the under-
cause lost.

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death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 36

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

No. 25 TENNYSBURY ST.

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME WILLIAM A STURGES
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 25 TENNYSBURY ST.
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death 2 years months days. In place of residence 12 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 26, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
May 29, 1939, to Feb 22, 1963
I last saw him alive on Feb 22, 1963, death is said to
have occurred on the date stated above, at 9:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

Due To (b) Arteriosclerotic heart disease 39yrs

Due To (c) Chronic Asthma 15yrs

OTHER SIGNIFICANT CONDITIONS Chronic Emphysema 10yrs

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify None

(Signature) Joseph Zambella, M. D.
(Print or Type Name)

(Address) 324 Summer St, East Boston, MA 02128

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAR 1 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed FEB 28 1963 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN MARRIED

11 If married, widowed, or divorced
HUSBAND of MARIE W AMIRAULT
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 53 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: WELDER
(Kind of work done during most of working life)

14 Industry or Business: CONSTRUCTION (BLDG.)

15 Social Security No. 349-01-1201

16 BIRTHPLACE (City) DEERFIELD
(State or country) ILL.

17 NAME OF FATHER WILLIAM STURGES

18 BIRTHPLACE OF FATHER (City) ELGIN
(State or country) ILL.

19 MAIDEN NAME OF MOTHER ANNIE ACTON

20 BIRTHPLACE OF MOTHER (City) DECATUR
(State or country) ILL.

21 Informant MARIE W STURGES

(Address) 25 TENNYSBURY ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sturges (3)

(Signature of Agent of Board of Health or other)

Health Officer 2-28-1963

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

FEB 28 1931

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit
of Health
Agent.

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Suffolk

(County)
Boston

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT BOSTON 37

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 183

No. New England Center Hospital

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)}

Mr. George Compton Day

PHYSICIAN — IMPORTANT

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) none

(a) Residence. No. 80 Johnson Avenue
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death, 47 years, months, days. In place of residence, 60 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 7 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
November 21 1962 January 7 1963

I last saw him alive on January 7 1963 death is said to
have occurred on the date stated above, at 2:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) TUBERCULOSIS, PULMONARY & BRONCHIAL 3 mos.

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? SPUTUM CULTURES & SMEARS

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Stewart Wright, M. D.

STEWART WRIGHT

(Address) New England Center Hospital Date 7 JAN 1963

6 Forest Hills Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 9, 1963

7 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons

ADDRESS 495 Commonwealth Ave, Boston

Received and filed JAN 9 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced
HUSBAND of Rosanna M. Bevelander
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 84 years 2 Months 21 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Caretaker (retired)
(Kind of work done during most working life)

14 Industry or Business: Real Estate

15 Social Security No. none

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

17 NAME OF FATHER John W. Day

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Eliza Cox

20 BIRTHPLACE OF MOTHER (City) England
(State or country)

21 Informant Rosanna Day
(Address) 80 Johnson Ave, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 1-8-63

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



MAR 13 1963 AM

for burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
cause, or compli-
which caused

ions, if any,
gave rise to
cause (a),
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cause last.

ditions contrib-
death but not
to the terminal
condition given

C.

34
R 94 1963

Director
use only
CK Ink.

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No.

1047

MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,
St. I give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James J. Sharkey

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, *W U I*
if so specify WARI)(a) Residence, No.
(Usual place of abode)

19 Buchanan Street

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death years 2 months 1 days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 29 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That we attempted deceased from
November 28 1963 to January 29 1963
I last saw him alive on January 29 1963, death is said to

have occurred on the date stated above, at 9:00a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Cerebral Artery
thrombosis, etc.

(b) Atherosclerosis

(c)

OTHER SIGNIFICANT CONDITIONS
Acute Tubular NecrosisINTERVAL
BETWEEN
ONSET AND
DEATH2 mos
years

3 wks

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) *Ch. L. Clay*, M. D.Charles L. Clay, M.D.
(Print or Type Name)

(Address Ass't. Dir., Mass. Gen'l Hosp. Date Jan. 29 1963)

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 1 1963

7 NAME OF FUNERAL DIRECTOR MAURICE H. KIRBY

ADDRESS WINTHROP

Received and filed FEB 1 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX <i>MALE</i>	9 COLOR <i>WHITE</i>	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN <i>MARRIED</i>
----------------------	-------------------------	--

11 If married, widowed, or divorced
HUSBAND of *ELLA J. THORNTON*
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGES 9 years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: *CLEANER*
(Kind of work done during most working life)

14 Industry or Business *LONG SLEEPING*

15 Social Security No. *021-09-0014*

16 BIRTHPLACE (City) *MASS*
(State or country)

17 NAME OF FATHER *JAMES P. SHARKEY*

18 BIRTHPLACE OF FATHER (City) *BOSTON*
(State or country) *MASS*

19 MAIDEN NAME OF MOTHER *MARY J. MACAULIFF*

20 BIRTHPLACE OF MOTHER (City) *GLoucester*
(State or country) *MASS*

21 Informant (Address) *MRS ELLA SHARKEY*

19 BUCHANAN ST WINTHROP MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Norma J. MacDonald
(Signature of Agent of Board of Health or other)

14985-1/31/63
(Official Designation) (Date of Issue of Permit)

RECEIVED



APR - 5 1963 AM

or burial permit
Board of Health
Persons Agent

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
cause, or comp-
which caused

is, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

11.c.

443

6-1
X26

5 1963

The Commonwealth of Massachusetts

40

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 1174

PLACE OF DEATH

Suffolk
(County)
Boston
(City or Town)

No. BOSTON CITY HOSPITAL

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME Martha Smith (HARDING)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WARY)

(a) Residence No. 2 Lorean Terr.
(Usual place of abode)

St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death... years... months... days. In place of residence 35 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 30, 1963
(Month) (Day) Was a patient

4 I HEREBY CERTIFY, Jan. 21, 1963 Jan. 30, 1963

1 death is said to have occurred on the date stated above, at 4:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac Insufficiency
(Clinical)

Due To (b) Hypertensive Cardiac Disease

OTHER SIGNIFICANT CONDITIONS

unknown Social Security No. 038-04-6140

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) M. WINTHROP O'CONNELL, M.D.
(Print or Type Name)

BOSTON CITY HOSPITAL Date 1-31-63

6 Pine Grove Lynn
(Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Feb. 6, 1963

7 NAME OF FUNERAL DIRECTOR W. C. Parker

ADDRESS Lynn, Mass.

Received and filed FEB 5 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX # 9 COLOR W 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of George Smith
(Husband's name in full)

12 AGE 85 Years 0 Months 23 Days If under 24 hours
Hours Minutes

13 Usual Occupation Secretary
(Kind of work done during most of working life)

14 Industry or Business Law

16 BIRTHPLACE (City), Lynn Mass
(State or country)

17 NAME OF FATHER John F. Harding

18 BIRTHPLACE OF FATHER (City), Lowell
(State or country) Vermont

19 MAIDEN NAME OF MOTHER Harriet Cassin

20 BIRTHPLACE OF MOTHER (City), Malone
(State or country) N.Y.

21 Informant Jeannette P. Thurgill

(Address) Cooper Lane, Buxton, Conn.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J. Dorato
(Signature of Agent of Board of Health or other)

14960 2/1/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

TVR-V

W. H. W. DOWE ATTORNEY

Charles D. Mackie

City Attorney

RECEIVED



APR - 5 1963 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

SUFFOLK
(County)
BOSTON
(City or Town)STANDARD
CERTIFICATE OF DEATH

Registered No. 1295

No. St. Elizabeth's Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN -- IMPORTANT

2 FULL NAME

FRANCIS J. SHEA

(First Name)

(Middle Name)

(Last Name)

(Was deceased a

U. S. War Veteran,

if so specify WAR) WW 1

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No.
(Usual place of abode)

63 PAINE

St.

WINTHROP

(If nonresident, give city or town and State)

Length of stay: In place of death, 15 years, months, days. In place of residence 35 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 4 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
1/20 1963 to 2/4 1963I last saw him alive on 2/4 1963, death is said to
have occurred on the date stated above, at 10:23 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MULTIPLE MYELOMA

Due To (b) PATHOLOGIC FRACTURE

(c) (OVER)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? YES

What test confirmed diagnosis? X-ray, necropsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

6 St. Joseph's West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 7, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed

FEB 7 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M

9 COLOR

W

10 SINGLE (write the word)

MARRIED MARRIED

10a If married, widowed, or divorced,
HUSBAND of Margaret Molloy

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 65 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Buyer Domestic

(Kind of work done during most of working life)

14 Industry or Business: Jordan Marsh Co

15 Social Security No. 013-07-9058

16 BIRTHPLACE (City) Worcester
(State or country) Mass

17 NAME OF FATHER

Michael Shea

18 BIRTHPLACE OF FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER Ellen Crowley

20 BIRTHPLACE OF MOTHER (City)

(State or country)

Ireland

21

Informant (Address)

Margaret Shea

63 Paine St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

J. Dorato Rg

(Signature of Agent of Board of Health or other)

B15047

2-6-63

(Official Designation)

(Date of Issue of Permit)

5 1963

RECEIVED



APR - 5 1963 AM

for burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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heart failure,
etc. It means
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gave rise to
cause (a),
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death but not
to the terminal
condition given

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Director

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CK Ink.

2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN

(City or Town making this return)

42

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 01513

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,
St.) give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME COLBERT MASON

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 7 Somerset Terrace, Winthrop, Massachusetts

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, years month 2 days. In place of residence, 31 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 9, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That he died deceased from

2-7, 19. 63, to 2-9, 19. 63

I last saw him alive on 2-9-63, 19. death is said to

have occurred on the date stated above, at 1:10a.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary edema

INTERVAL
BETWEEN
ONSET AND
DEATH
1 Day

(b) Due To Coronary heart disease

Link
Years

(c) Due To

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles L. Cloy, M.D.

Charles L. Cloy, M.D.
(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Feb 9 1963

6 Woodlawn Creamatory Everett, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF CREMATION Feb. 12, 1963

7 NAME OF FUNERAL Alfred B. Marsh

ADDRESS 74 Winthrop St. Winthrop

Received and filed FEB 14 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male	9 COLOR white	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN single
---------------	------------------	---

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 80 Years 9 Months 12 Days

If under 24 hours
Hours Minutes

13 Usual Occupation: retired draftsman

(Kind of work done during most working life)

14 Industry or Business: American Mutual Ins. Co.

15 Social Security No.

16 BIRTHPLACE (City) England

17 NAME OF FATHER Frederick Mason

18 BIRTHPLACE OF FATHER (City) England

19 MAIDEN NAME OF MOTHER Virginia Allen

20 BIRTHPLACE OF MOTHER (City) Ox ord England

21 Informant Miss. Ella Lason

(Address)

7 Somerset Terrace, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued

(Signature of Agent of Board of Health or other)

Official Designation

(Date of Issue of Permit)

A TRUE COPY ATTEST:

TRUE COPY. ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



APR 28 1963 AM

THIS IS A
ENT RECORD.
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APPROVED

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CTIONS
FOR

CERTIFICATE

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OF DEATH

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Chapter 137,
954, requires
s to print or
cause or
death on
ificates.

P. 46. 39 9 &

P. 114 145,

AP. 38 16.)

8.1963

376

PLACE OF DEATH

Suffolk
(County)

Boston
(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. *01869*

No. *Neponset Manor Hospital*

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME. *NEPONSET MANOR HOSPITAL Catherine F. Ellis*
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR) *No*

(a) Residence, No. *4 Waldemar Ave*
(Usual place of abode)

Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death *1* years *00* months *00* days. In place of residence *00* years *00* months *00* days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *Feb 19 1963*
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb 18, 1962, to Feb 19, 1963
I last saw him alive on *Feb 19, 1963*, death is said to
have occurred on the date stated above, at *9:15 P.M.*

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Cerebral thrombosis*
with congested heart *8 days*

Due To *Generalized*
(b) *arterio-sclerosis* *4 yrs.*

Due To *with heart disease*
(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? *No*
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? *No*
If so, specify

(Signed) *Myron B. Rosenthal*, M. D.

(Address) *941 Montrose St* Date *2/19/63*

6 *Winthrop* *Winthrop*
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *Feb 23* 19*63*

7 NAME OF FUNERAL DIRECTOR *Arthur J. O'Maley*

ADDRESS *Winthrop, Mass*

Received and filed *Feb 21 1963*

Charles H. Mackie 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *Female* 9 COLOR *White* 10 SINGLE (write the word)
MARRIED *Widowed*
WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of

(or) WIFE of *Harry Ellis*
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE *96* Years *00* Months *00* Days
If under 24 hours
Hours Minutes

13 Usual Occupation: *Retired Practical Nurse*
(Kind of work done during most of working life)

14 Industry or Business: *Nursing*

15 Social Security No.

16 BIRTHPLACE (City) *Boston* (State or country) *Mass*

17 NAME OF FATHER *Charles Coakley*

18 BIRTHPLACE OF FATHER (City) *Ireland* (State or country)

19 MAIDEN NAME OF MOTHER *Nora King*

20 BIRTHPLACE OF MOTHER (City) *Ireland* (State or country)

21 Informant *Catherine Derry* (Address) *4 Waldemar Ave Winthrop*

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
R. C. Gorman

(Signature of Agent of Board of Health or other)

15270

2 20 63

(Official Designation)

(Date of Issue of Permit)

Handwritten text, possibly a signature or address, mostly illegible due to fading.

RECEIVED



APR - 8 1963 AM

For burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
the, or compli-
which caused

ons, if any,
gave rise to
cause (a),
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death but not
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661

8 1963

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN 44

(City or Town making this return)

Suffolk

(County)

Boston

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 01864

No. New England Deaconess Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Walter Massucco (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WARI. No

(a) Residence. No. 187 Shore Drive St. Winthrop Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death years months 8 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 19 1963 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 13 1950 to February 19 1963

1 last saw him alive on February 18 1963, death is said to have occurred on the date stated above, at 6:20 Am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PULMONARY EMPHYSEMA YRS

Due To CORONARY THROMBOSIS 2 DAYS

(b) SECONDARY POLYCYTHEMIA YRS

(c) OTHER SIGNIFICANT CONDITIONS

DIABETES MELLITUS YRS

Was autopsy performed? no

What test confirmed diagnosis? PHYSICAL EXAM EKG

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Carey M. Peters M. D.

(Address) 1180 Beacon St. Date 19 Feb 1963

St. Michael's Cem. Boston

DATE OF BURIAL Feb. 22, 1963

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 10 N. Bennett St. Boston

Received and filed FEB 21 1963

Charles H. Inzkie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced HUSBAND OF Dorothy Lorcetz (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 6 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Executive Director (Kind of work done during most of working life)

14 Industry or Business M. T. A.

15 Social Security No.

16 BIRTHPLACE (City) Boston (State or country) Mass.

17 NAME OF FATHER Domenic Massucco

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

19 MAIDEN NAME OF MOTHER Susan Biggi

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant Dorothy Massucco

(Address) 187 Shore Drive, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) 15260 2 20 63

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

TVA ✓

APR - 8 1963 AM

For burial permit
rd of Health
Agent.

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eath but not
the terminal
ndition given

C.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 15

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Rebecca Kaminsky Litner
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 252 Shirley St
(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 2 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
APRIL 2, 1955, to MARCH 2, 1963

I last saw h. alive on MAR 2, 1963 death is said to
have occurred on the date stated above, at 9:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCIDENT

Due To (b) ARTERIO-SCLEROTIC HEART DIS 1 YR.

Due To (c) FRACTURED LEFT HIP 16 DAYS

OTHER SIGNIFICANT CONDITIONS CHRONIC LYMPHATIC LEUKEMIA 1 YR
CHRONIC BRONCHIAL ASTHMA 8 YRS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & X-ray.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron H. King, M. D.

(Print or Type Name) MYRON H. KING M.D.

(Address) 211 DEANSTON ST. BOSTON Date 3/2 1963

6 Sharon Mem. Park Sharon
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 3 1963

7 NAME OF FUNERAL DIRECTOR Henry Levine

ADDRESS 470 Harvard St. Brookline

Received and filed MAR 4 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR white 10 SINGLE (write the word) MARRIED widow WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Morris Litner (Husband's name in full)

12 AGE 76 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: House Wite (Kind of work done during most working life)

14 Industry or Business: AT Home

15 Social Security No. NONE

16 BIRTHPLACE (City) Russia (State or country)

17 NAME OF FATHER Herman Kaminsky

18 BIRTHPLACE OF FATHER (City) Russia (State or country)

19 MAIDEN NAME OF MOTHER ETTA (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) Russia (State or country)

21 Informant (Address) Sidney H. Litner

330 CLINTON RD. Brookline

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Skirianski (Signature of Agent of Board of Health or other)

Health Officer March 2, 1963 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

TUP.V

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Suffolk

(County)

Winthrop

(City or Town)


 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

 STANDARD
 CERTIFICATE OF DEATH

Registered No. 46

 No. Winthrop Community Hospital St. (If death occurred in a hospital or institution,
 St. { if its NAME instead of street and number)

 2 FULL NAME Mabel T Voorhees
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

 (Was deceased a U. S. War Veteran, No
 if so specify WAR)

 (a) Residence, No. 66 Shore Drive St. Winthrop
 (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, years 1 months 5 days. In place of residence, 8 years months days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH 3 2 1963
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from
 JANUARY 24 1963, to MARCH 2 1963

 I last saw him alive on MARCH 1 1963, death is said to
 have occurred on the date stated above, at 7:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) HYPOSTATIC PNEUMONIA

 INTERVAL
 BETWEEN
 ONSET AND
 DEATH

2 DAYS

Due To (b) CARDIAC DECOMPENSATION

2 WEEKS

Due To (c) ARTERIOSCLEROTIC HEART DISEASE

5 YRS

 OTHER SIGNIFICANT CONDITIONS
 FRACTURE SURGICAL NECK
 LEFT HUMERUS

6 WKS

Was autopsy performed? NO

What test confirmed diagnosis? EKG - X-RAYS

Was disease or injury in any way related to occupation of deceased? NO

Also specify

(Signature) Dorothy Cheney Appleton, M. D.

 DOROTHY CHENEY APPLETON
 (Print or Type Name)

(Address) 197 Woodside Ave Date MAR 2 1963

WINTHROP, MASS

 6 Woodlawn Everett Mass
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 4 1963

 7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
 O'Maley Funeral Home

ADDRESS Winthrop Mass.

MAR 4 1963

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

 8 SEX F 9 COLOR white 10 SINGLE (write the word)
 MARRIED widow
 WIDOWED
 DIVORCED
 UNKNOWN

 11 If married, widowed, or divorced
 HUSBAND of (Give maiden name of wife in full)

 (or) WIFE of Garret S. Voorhees
 (Husband's name in full)

 12 AGE 86 6 Months 13 Days If under 24 hours
 Hours Minutes

 13 Usual Occupation: Housewife
 (Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. None

 16 BIRTHPLACE (City) Newark
 (State or country) New Jersey

17 NAME OF FATHER John Tobin

 18 BIRTHPLACE OF FATHER (City) Newark
 (State or country) New Jersey

19 MAIDEN NAME OF MOTHER Laura Drake

 20 BIRTHPLACE OF MOTHER (City) Newark
 (State or country) New Jersey

 21 Informant G. Coerte Voorhees
 (Address)

1047 Amsterdam Ave New York 25 N Y

I HEREBY CERTIFY that a satisfactory standard certificate of death

was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Aronson (Signature of Agent of Board of Health or other)

 Ralph E. Aronson
 (Official Designation)

 March 4-1963
 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

es not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which caused

ms, if any,
ave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
condition given

C.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 47

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 231 Court Road

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Madeline Frasso (Cioppa)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) no

(a) Residence. No. 231 Court Road
(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 1 years 1 months 1 days. In place of residence 1 years 1 months 1 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 3, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
MAY 15 1959 to MAR 3 1963
I last saw him live on MAR 3 1963 death is said to
have occurred on the date stated above, at 3:20 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF GALL BLADDER 3mo

Due To (b) WITH METASTASIS TO

Due To (c) LIVER WITH JAUNDICE 1mo

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? PATHOLOGICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron H. King M. D.

MYRON H. KING
(Print or Type Name)

(Address) 222 Pleasant St. Date 3/14/1963
WINTHROP

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 6, 1963

7 NAME OF FUNERAL DIRECTOR Ernest P. Cagliano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 5 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Anselmo Frasso
(Husband's name in full)

12 AGE 65 Years 9 Months 20 Days If under 24 hours
Hours Minutes

13 Usual Occupation: housewife
(Kind of work done during most working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Giovanni Cioppa

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Angelina Graziano

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Anselmo Frasso
(Address) 231 Court Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seranno
(Signature of Agent of Board of Health or other)
Health Officer (Official Designation) March 5, 1963 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
re than one
se for each
, (b) and (c)

does not mean
ode of dying,
s heart failure,
a, etc. It means
ease, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 48

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Michael Sheehan

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, NO
if so specify WAR)

(a) Residence. No. 83 Chester Ave. Winthrop Mass
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 13 days. In place of residence 7 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 4 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
2/15/63, to 3/4/63, 1963

I last saw him alive on 3/3/63, death is said to
have occurred on the date stated above, at 12:05 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) HEPATIC SCLEROSIS 1 YR

Due To GENERAL ARTERIO SCLEROSIS 2 YRS

Due To HEART DIS - MYOCARDIAL 2 YRS

OTHER SIGNIFICANT CONDITIONS BRONCHITIS & PNEUMONIA 2 YRS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL EXAM

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron D. King, M. D.

(Print or Type Name) MYRON D. KING M.D.

(Address) 125 BROADWAY ST. Date 3/4/63

6 HOLY CROSS CEMETERY MALDEN, MASS.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 7, 1963

7 NAME OF FUNERAL DIRECTOR JOHN G. WELSH

ADDRESS 718 BROADWAY CHELSEA, MASS.

Received and filed MAR 5 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN WIDOWED

11 If married, widowed or divorced
HUSBAND of JULIA DEASY
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 81 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation LABORER
(Kind of work done during most working life)

14 Industry or Business CHELSEA CLOCK CO.

15 Social Security No. 032-01-7879A

16 BIRTHPLACE (City) IRELAND
(State or country)

17 NAME OF FATHER EDWARD SHEEHAN

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER MARY DRINAN

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant (Address) SISTER JOSEPH MIRIAM S.P.

16 TUDOR ST. CHELSEA, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
re than one
se for each
, (b) and (c)

does not mean
ode of dying,
s heart failure,
a, etc. It means
ease, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

11. 21

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

A h

2 FULL NAME. Ethel Tompkins Anderson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 26 Beacon St. Winthrop Mass

(Usual place of abode)

Length of stay: In place of death.....years.....months.....3.....days. In place of residence.....50.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 6 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
MAR. 2, 1963, to MAR. 6, 1963.I last saw her alive on MARCH 6, 1963, death is said to
have occurred on the date stated above, at 5:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC DECOMPENSATION

Due To (b) RHEUMATIC HEART DISEASE

Due To (c)

OTHER SIGNIFICANT CONDITIONS BRONCHO PNEUMONIA
LEFT BREAST AMPUTATED

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) A. N. Caplan M.D., M. D.

(Print or Type Name)

(Address) 8 SPRINGFIELD ST. Date 3-6-1963

6 Winthrop Winthrop Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 8, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass.

Received and filed MAR 7 1963

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 49

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Ernest Anderson
(Husband's name in full)12 AGE 50 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. 019-14-6558

16 BIRTHPLACE (City) Lynn Mass
(State or country)

17 NAME OF FATHER Lester Thompkins

18 BIRTHPLACE OF FATHER (City) New York
(State or country) New York

19 MAIDEN NAME OF MOTHER Marion Gundersen

20 BIRTHPLACE OF MOTHER (City) Norway
(State or country)21 Informant Helen McEachern
(Address)

62 Beacon St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) March 7, 1963

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1 R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
or compli-
which causedns, if any,
have rise to
cause (a),
the under-
cause last.ions contrib-
death but not
the terminal
condition given

1) -

Chapter 137,
1954, requires
ns to print or
e cause or
of death on
rtificates.

50M-5-56-817573

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 50

No. Braemar Rest Home St. (If death occurred in a hospital or institution,
St. give its NAME instead of street and number)2 FULL NAME Francis Musle
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)

(a) Residence. No. 11 Moore St St. (If nonresident, give city or town and State)

Length of stay: In place of death. 1 years - months 7 days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 6 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,I last saw h alive on , 19, death is said to
have occurred on the date stated above, at 5:45 P. m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably to natural

(b) Causes, possibly either an acute
coronary occlusion or a cerebral
embolus.(c) Winthrop Board of Health
Charles LibermanOTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Charles Liberman, M. D.

(Address) Winthrop, Mass Date 3/6/ 1963

6 March 9 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 9 1963

7 NAME OF FUNERAL DIRECTOR Ernest Plagiano

ADDRESS 147 Winthrop St Winthrop

Received and filed MAR 11 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Divorced
WIDOWED or DIVORCED10a If married, widowed or divorced
HUSBAND of Mary Fitzgerald
(Give maiden name of wife in full)(or) WIFE of Josephine H. Pucko
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 53 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Stevedore
(Kind of work done during most of working life)

14 Industry or Business: Longshoreman

15 Social Security No. 022-16-6389

16 BIRTHPLACE (City) East Boston
(State or country) Mass

17 NAME OF FATHER ? Musle

18 BIRTHPLACE OF FATHER (City) ?
(State or country)

19 MAIDEN NAME OF MOTHER Mary Doherty

20 BIRTHPLACE OF MOTHER (City) ?
(State or country)21 Informant John Fitzpatrick
(Address) 700 Haverhill St ReadingI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Siranni
(Signature of Agent of Board of Health or other)Health Officer March 11, 1963
(Official Designation) (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteen, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 51

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

55 Bellevue Ave.

No.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Minnie G (Davis) Abbott
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
(if so specify WAR)

(a) Residence. No. 55 Bellevue Ave.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years months 14 days. In place of residence years months 30 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 10 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
November 20, 1952, to MARCH 10, 1963
I last saw him alive on MARCH 9, 1963, death is said to
have occurred on the date stated above, at 10:00 A.M.

INTERVAL
BETWEEN
ONSET AND
DEATH
1 DAY

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INSUFFICIENCY

Due To (b) HYPERTENSIVE HEART DISEASE
(c) HYPERTENSION

5 YRS
10 YRS

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Dorothy Cheney Appleton M. D.
DOROTHY CHENEY APPLETON
(PRINT OR TYPE SIGNATURE)

(Address) 197 Woodside Ave. WINTHROP, MASS. Date MARCH 11, 1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 15 1963

7 NAME OF FUNERAL DIRECTOR Howard E. Reynolds
ADDRESS WINTHROP, MASS.

Received and filed MAR 12 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED widow
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Albert M. Abbott
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 2 Months 21 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. 0-2-03-1027

16 BIRTHPLACE (City) Birmingham
(State or country) England

17 NAME OF FATHER Francis Davis

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Elizabeth

20 BIRTHPLACE OF MOTHER (City) England
(State or country)

21 Informant Albert L. Abbott
(Address) 4 Bald Rock Rd. Cohasset, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
Heal B. Offin March 12, 1963
(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
use, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

Chapter 137,
1954, requires
ans to print or
the cause or
of death on
certificates, and
48, Acts of
requires Physi-
print or type
under signature.

1 V.P. V

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



MAR 12 1963 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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not enter
more than one
for each

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

does not mean
of dying,
heart failure,
etc. It means
cause, or compli-
which caused

conditions, if any,
gave rise to
cause (a),
the under-
cause last.

conditions contrib-
death but not
to the terminal
condition given

1, C.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 52

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 17 Cutler St.

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ida Sarah Tick Doodlesack
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 17 Cutler St. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years.....months.....days. In place of residence 3 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 10 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
July 1952, to MARCH 10 1963
I last saw him alive on MARCH 10 1963, death is said to
have occurred on the date stated above, at 7:00 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Coronary Artery 3 yrs.
Due To Heart Disease
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

NONE

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 3/10/1963

6 Isaac Elchonon Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 12 1963

7 NAME OF
FUNERAL DIRECTOR Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed MAR 11 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED Divorced
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Hyman Doodlesack
(Husband's name in full)

12 AGE 77 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: House-wife
(Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No. none

16 BIRTHPLACE (City) Poland
(State or country)

17 NAME OF FATHER William Blotnick

18 BIRTHPLACE OF FATHER (City) Poland
(State or country)

19 MAIDEN NAME OF MOTHER Esther (unknown)

20 BIRTHPLACE OF MOTHER (City) Poland
(State or country)

21 Informant William Tick
(Address) 40 Court St., Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scarnone (S)
(Signature of Agent of Board of Health or other)

Health Officer March 11 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

THIS IS A
NENT RECORD.
se only

APPROVED
ink or black
writer ribbon.

STRUCTIONS
FOR
L CERTIFICATE

n giving
OF DEATH

not enter
than one
se for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
are, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
to the terminal
condition given

h.c.

Chapter 137,
1954, requires
ans to print or
be cause or
of death on
certificates.

HAP. 46. §§ 9 &

HAP. 114 §§ 45,

HAP. 38 § 6.)

The Commonwealth of Massachusetts



EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 53

No. 21 Pearl Avenue, Winthrop

{(If death occurred in a hospital or institution,
St. [give its NAME instead of street and number])

2 FULL NAME MORRIS BARD
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a
U. S. War Veteran, NO
if so specify WAR)

(a) Residence. No. 21 Pearl Avenue St. Winthrop Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years months days. In place of residence 3 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 12 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JULY 28, 1950, to MAR 12, 1963

I last saw h/a alive on MAR 12, 1963, death is said to
have occurred on the date stated above, at 8:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY INFARCTION

INTERVAL
BETWEEN
ONSET AND
DEATH
15 MIN

Due To (b) CHRONIC MYOCARDIAL DIS
+ ARTERIO-SCLEROTIC HEART DIS 14 YRS.

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron H. King MD, M. D.
24 PLEASANT ST
(Address) WINTHROP MASS Date MAR 12 1963

6 Beth El. Cem Baker St W Rox.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 13th 63

7 NAME OF FUNERAL DIRECTOR Philip Briss
ADDRESS 470 Harvard St Brookline Mass

Received and filed MAR 13 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED married
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Dora Shapiro
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: self employed
(Kind of work done during most of working life)

14 Industry or Business: Merchant

15 Social Security No. UNKNOWN

16 BIRTHPLACE (City) Israel
(State or country)

17 NAME OF FATHER Isaac Bard

18 BIRTHPLACE OF FATHER (City) Israel
(State or country)

19 MAIDEN NAME Gittel (unknown)
OF MOTHER

20 BIRTHPLACE OF MOTHER (City) Israel
(State or country)

21 Informant Dora Bard
(Address) 21 Pearl Ave. Winthrop Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Striann (3)

(Signature of Agent of Board of Health or other)
Heath (Official Designation) March 13, 1963
(Date of Issue of Permit)

RECEIVED

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



MAR 1 1983 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

IT OR TYPE
E OR CAUSES
F DEATH

do not enter
more than one
use for each
(a), (b) and (c)

does not mean
mode of dying,
as heart failure,
a, etc. It means
cause, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
ng the under-
cause last.

conditions contrib-
to death but not
to the terminal
condition given

PLACE OF DEATH

SUFFOCK

(County)

WINTHROP

(City or Town)

No. WINTHROP CONV. HOME

2 FULL NAME KATHARINE MCISAAC
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence, No. 73 WOODSIDE AVE. St. WINTHROP MASS.
(Usual place of abode) (City or town and State)

Length of stay: In place of death.....years. 2 months.....days. In place of residence 18 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 16 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 6-19-59 to 3-16-63, 19.....

I last saw her alive on 3-16-63, 19....., death is said to have occurred on the date stated above, at 10:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) UREMIA. 1 WEEK

(b) Due To ARTERIOSCLEROSIS 20 yrs

(c) Due To CHRONIC NEPHRITIS 1 YEAR

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) A. N. Caplan, M. D.

A. N. CAPLAN M.D.
(Print or Type Name)

(Address) 186 PRINCETON ST. FEB. 3-18 1963

6 WINTHROP CEM. WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 19, 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS 210 WINTHROP MASS.

Received and filed MAR 19 1963 19.....

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 51

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED SINGLE
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 95 Years - Months - Days If under 24 hours
Hours Minutes13 Usual Occupation MAID
(Kind of work done during most of working life)

14 Industry or Business HOUSE WORK

15 Social Security No. 025-26-5848

16 BIRTHPLACE (City) NOVA SCOTIA
(State or country)

17 NAME OF FATHER HUGH MCISAAC

18 BIRTHPLACE OF FATHER (City) NOVA SCOTIA
(State or country)

19 MAIDEN NAME OF MOTHER NOT KNOWN

20 BIRTHPLACE OF MOTHER (City) NOVA SCOTIA
(State or country)21 Informant MRS. EDWARD HANNAFORD
(Address) 75 WOODSIDE AVE. WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sircum (S)
(Signature of Agent of Board of Health or other)
Health Officer March 19 1963
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the following rules of practice: **MAR 1 9 1963 AM**

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH
(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

1 PLACE OF DELIVERY
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital

Registered No. 55

2 NAME OF FETUS Baby Boy Imbrici
(if given)

3 DATE OF DELIVERY March 18, 1963
(Month) (Day) (Year)

4 SEX Male ☒ Female Undetermined

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single ☒ Twin Triplet

7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd

8 FATHER
FULL NAME Ralph Imbrici

14 MOTHER
MAIDEN NAME Doris Larlee
PRESENT NAME Doris Imbrici

9 RESIDENCE, NO. 16 Paris Street
CITY OR TOWN E. Boston, STATE Mass.

15 RESIDENCE, NO. 16 Paris
CITY OR TOWN E. Boston, STATE Mass.

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 49 (Years)

16 COLOR OR RACE W 17 AGE AT TIME OF THIS DELIVERY 38 (Years)

12 PLACE OF BIRTH Italy

18 PLACE OF BIRTH Maine
(City or Town) (State or country)

13 OCCUPATION Retired

19 INFORMANT Ralph Imbrici (father)

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

(a) How many children are now living? 3

(b) How many children were born alive but are now dead? 0

(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY 40 completed weeks

22 WEIGHT OF FETUS 8 Lb. 15 Oz.
(or Grams)

23 WHEN DID FETUS DIE X
Before Labor During Labor or Delivery Unknown

24 AUTOPSY Yes No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prolapse of Cord

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

26 Place of Burial or Cremation Holy Cross Cemetery Malden
(City or Town)
DATE OF BURIAL March 22 1963

27 NAME OF FUNERAL DIRECTOR Vincent Rapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed MAR 21 1963 19

A TRUE COPY ATTEST

Registrar

I HEREBY CERTIFY that this delivery occurred on the date stated above at 7:20A.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:
Maurice Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)

Address 73 Bartlett Road Date 3/18 1963

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)
Health Officer March 21, 1963
(Official Designation) (Date of Issue of Permit)

FETAL DEATH
RECEIVED

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

PLACE OF DEATH

1

Essex

(County)

Danvers

(City or Town)

Danvers State Hospital, Hathorne

No. (If death occurred in a hospital or institution, give its NAME instead of street and number)

William H. Frizzell

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

56 Main

(a) Residence. No. (Usual place of abode)

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death 2 years 10 months 18 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 19, 1963

4 I HEREBY CERTIFY That I attended deceased from April 30, 1961 to March 19, 1963

I last saw him on March 19, 1963 at 3:30 a.m. Death is said to have occurred on the date stated above, at

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia (Right Side)

(b) Due To Arteriosclerotic heart disease

(c) Due To

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Willard M. Hausman, M. D. Willard M. Hausman

(Address) Hathorne, Mass. Date 3/20/ 1963

6 Winthrop Cemetery, Winthrop (City or Town)

DATE OF BURIAL March 22, 1963

7 NAME OF FUNERAL DIRECTOR Maurice Kirby Winthrop, Mass.

ADDRESS

Received and filed APR 4 1963

(Registrar of City or Town where deceased resided)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 56

(If death occurred in a hospital or institution, give its NAME instead of street and number)

(Was deceased a U. S. War Veteran, if so specify WAR, No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN married

11 If married, widowed or divorced HUSBAND of Adeline Reed (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 80 7 28 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Steamfitter (Kind of work done during most working life)

14 Industry or Business: Not Determined

15 Social Security No. Unknown

16 BIRTHPLACE (City) Canada (State or country)

17 NAME OF FATHER David Frizzell

18 BIRTHPLACE OF FATHER (City) Unknown (State or country) Canada

19 MAIDEN NAME OF MOTHER Emily Oakes

20 BIRTHPLACE OF MOTHER (City) Paris (State or country) France

21 Informant Mary E. Sheehan (Address) Hathorne, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED March 21, 1963

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



APR 1 1963 AM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

not enter
re than one
se for each
, (b) and (c)

does not mean
code of dying,
s heart failure,
a, etc. It means
ease, or compli-
which caused

itions, if any,
e have rise to
e cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

on, c.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 42 Pearl Ave., Winthrop, Mass.

(H26 169)

Abraham

Harold

Turransky

2 FULL NAME. (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 42 Pearl Ave.
(Usual place of abode)

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death. 7 years.....months.....days. In place of residence 27 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 24 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 50, to March 24, 1963.

I last saw him live on MARCH 21, 1963, death is said to have occurred on the date stated above, at 1:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion. 1 hour.

(b) Hypertensive. Coronary ARTERY Ht. Disease. 18 months

(c)

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS. 3yrs.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) CHARLES LIBERMAN M. D.

(Print or Type Name)

(Address) WINTHROP, MASS. Date 3/24/1963

Sharon Memorial Park, Sharon

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL 24 March 1963

7 NAME OF FUNERAL DIRECTOR Benj. F. Solomon

ADDRESS 420 Harvard St. Brookline

Received and filed MAR 25 1963 19

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 57

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Ruth Epstein (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 52 Years.....Months.....Days If under 24 hoursHours.....Minutes

13 Usual Occupation: salesman (Kind of work done during most working life)

14 Industry or Business: Sundries & paper

15 Social Security No. 011-09-5893

16 BIRTHPLACE (City) (State or country) Boston

17 NAME OF FATHER Ralph Turransky

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Annie Finn

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant wife Ruth Turransky (Address)

42 Pearl Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Turransky (31)
(Signature of Agent of Board of Health or other)Health Officer March 25 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



MAR 25 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

INSTRUCTIONS
FOR
L CERTIFICATE

not giving
OF DEATH

not enter
e than one
e for each
, (b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ditions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given
D.C.

Chapter 137,
of 1954 requires
cians to print or
the cause or
s of death on
certificates, and
ter 48, Acts of
requires Physi-
to print or type
under signature.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 95 Main Street, Winthrop

2 FULL NAME

Eleanor L. Waggett (McGurn)

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No.

95 Main Street, Winthrop

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death. 12 years.....months.....days. In place of residence. 12 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

March 25, 1963

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at 3:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To natural causes, namely

(b) generalized and coronary

(c) artery arteriosclerosis.

OTHER SIGNIFICANT CONDITIONS complicated by diabetes mellitus of 40 years duration

Was autopsy performed? Winthrop Board of Health

What test confirmed diagnosis? Charles Liberman

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles Liberman, M.D.

(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP Date 3/26/1963

6 Holyhood Cemetery, Brookline

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 28th 1963

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed MAR 26 1963

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD
CERTIFICATE OF DEATH

Registered No. 58

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 CITIZEN
OF U.S.

11 SINGLE
MARRIED
WIDOWED
DIVORCED
UNKNOWN

Female White

YES ☒ NO ☐

11a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Andrew J. Waggett

(Husband's name in full)

12 DATE OF BIRTH Sept. 6, 1870

13

AGE 92 years 6 months 19 days

If under 24 hours

Hours.....Minutes

14 Usual

Occupation: Housewife

(Kind of work done during most of working life)

15 Industry

or Business: At home

16 Social Security No.

None

17 BIRTHPLACE (City)

Boston

(State or country)

Mass.

18 NAME OF
FATHER

Owen McGurn

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

20 MAIDEN NAME

OF MOTHER

Mary Morrow

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

22

Informant

(Address) Miss Catherine B. Waggett-dau.
95 Main St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Scramm, Jr.

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

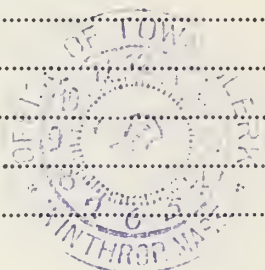
March 26, 1963

(Date of Issue of Permit)

(Registrar)

J.B.V.

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

c.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Mount Convalescent Home, Inc.

2 FULL NAME

Roland Erle Davison

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No.

2 Washington Terrace

(Usual place of abode)

Length of stay: In place of death, years, months, days. In place of residence, 81 years, 2 months, 21 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 29 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1960, to March 29, 1963.

I last saw him live on March 27, 1963, death is said to have occurred on the date stated above, at 5:30a.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic disease

Due To Generalized arteriosclerosis

Due To Parkinsons disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical & lab

5 Was disease or injury in any way related to occupation of deceased? no

(Signature) M. Traunstein, Jr., M.D.

M. Traunstein, Jr., M.D.

(Print or Type Name)

(Address) 73 Bartlett Rd. Date 3-30 1963

6 Winthrop Cemetery Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 1, 1963

7 NAME OF FUNERAL DIRECTOR

Alfred B. Marsh

ADDRESS 174 Wintrop Street, Winthrop

Received and filed

APR 1 1963

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

59

No. Mount Convalescent Home, Inc. (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

Male White

11 If married, widowed, or divorced
HUSBAND of Alice Abbott Munday
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 81 Years, 2 Months, 20 Days

If under 24 hours
Hours Minutes13 Usual Occupation: Hotel office Mgr.
(Kind of work done during most working life)

14 Industry or Business: General Electric Co.

01-205-3423-A

15 Social Security No. 01-205-3423-A

16 BIRTHPLACE (City) Winthrop Massachusetts

17 NAME OF FATHER John Woodbury Davison

18 BIRTHPLACE OF FATHER (City) Gloucester Massachusetts

19 MAIDEN NAME OF MOTHER Lovicy White

20 BIRTHPLACE OF MOTHER (City) Plymouth Vermont

21 Informant Mrs. Alice Davison
(Address) 2 Washington Terrace, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Alfred B. Marsh

(Signature of Agent of Board of Health or other)

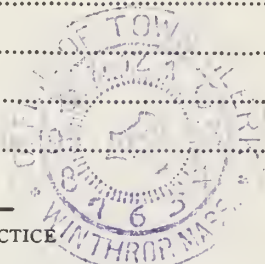
Health Officer

April 1, 1963

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-303

for burial permit
Board of Health
its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

• If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M. 3-62-932695

PLACE OF DEATH

SUFFOLK

(County)
WINTHROP

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 60

No. 304 Pleasant St.,

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME CARLE W. MALLEY (O'Malley)

(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 304 Pleasant St.,
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 35 years 3 months 35 days. In place of residence 35 years 3 months 35 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 29, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)

ACUTE MYOCARDIAL
INFARCTION

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19. retired worker

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?

(Specify type of place)

Manner of

Injury

(How did injury occur?)

Nature of

Injury

While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.

(Print or Type Name)

(Address) Boston Date 3/30/63

7 Grove Cemetery Free port, Maine

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 3, 1963

8 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed 19.

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

male

white

married

12 If married, widowed, or divorced

HUSBAND of

Effie Lee Pooler

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE

69

Years

9

Months

60

Days

If under 24 hours

Hours Minutes

Occupation

(Kind of work done during most of working life)

15 Industry

or Business

dry goods wholesale

16 Social Security No.

032-14-5284

17 BIRTHPLACE (City)

Lowell

(State or country)

Massachusetts

18 NAME OF

FATHER

George Sherman O'Malley

19 BIRTHPLACE OF

FATHER (City)

Lowell

(State or country)

Massachusetts

20 MAIDEN NAME

OF MOTHER

Georgia Anna March

21 BIRTHPLACE OF

MOTHER (City)

Unity

(State or country)

Maine

22

Informant

(Address)

Mrs. Carle E. O'Malley

304 Pleasant St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transfer permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer

(Date of Issue of Permit)

April 2, 1963

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

INSTRUCTIONS
FOR
DEATH CERTIFICATEn giving
OF DEATHnot enter
than one
for each
, (b) and (c)does not mean
of dying,
heart failure,
etc. It means
cause, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.itions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates.

50M-1-58-921876

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATHRegistered No. 611 PLACE OF DEATH
Suffolk
(County)
Winthrop
(City or Town)No. 37 Bellevue Ave. (If death occurred in a hospital or institution,
St. [give its NAME instead of street and number])2 FULL NAME Stephen D. CASASSA
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence. No. 37 Bellevue Ave. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death _____ years _____ months _____ days. In place of residence 5 years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 30 - 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
_____, 19____, to _____, 19____I last saw h. alive on _____, 19____, death is said to
have occurred on the date stated above, at 3:45 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death due to natural
causes presumably(b) acute coronary
occlusion bases on(c) history.OTHER
SIGNIFICANT
CONDITIONS Winthrop Board of Health
Charles Lieberman, MD

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify _____(Signed) Charles Lieberman, M. D.(Address) Winthrop Date 3/31/19636 Winthrop Winthrop
Place of Burial or Cremation (City or Town)DATE OF BURIAL April 2 - 19637 NAME OF
FUNERAL DIRECTOR Arthur S. Porce IIADDRESS 826 Winthrop Ave BostonReceived and filed APR 1 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married10a If married, widowed, or divorced
HUSBAND of EMMA R. SORACCO
(Give maiden name of wife in full)(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years 1 Months 23 Days
If under 24 hours
Hours _____ Minutes _____13 Usual
Occupation: Retired -
(Kind of work done during most of working life)14 Industry
or Business: Basket Dealer

15 Social Security No. _____

16 BIRTHPLACE (City) Boston
(State or country) MASS17 NAME OF
FATHER MARIO CASASSA18 BIRTHPLACE OF
FATHER (City) Italy
(State or country)19 MAIDEN NAME
OF MOTHER Rose CAVAGNARO20 BIRTHPLACE OF
MOTHER (City) Italy
(State or country)21 Informant Mrs Emma R. Casassa
(Address) 37 Bellevue Ave - WinI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer April 1, 1963
(Official Designation) (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original, interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during the last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

PLACE OF DELIVERY

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)

Registered No. 62

2 NAME OF FETUS Baby Boy Velardo
(if given)

3 DATE OF DELIVERY March 30, 1963
(Month) (Day) (Year)

4 SEX Male ☒ Female ☐ Undetermined ☐

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single ☒ Twin ☐ Triplet ☐

7 IF MULTIPLE BIRTH, BORN:
1st 2nd 3rd

In giving
CAUSE OF
FETAL DEATH

do not enter
more than one
cause for each
of (a), (b)
and (c)

etal or maternal
condition causing
etal death (do
not use such
terms as stillbirth
prematurity.)

etal and/or ma-
ternal conditions,
any, which gave
rise to above
use (a), stating
the underlying
cause last. →

→
conditions of fetus
mother which
may have contrib-
uted to fetal
death, but, in so
far as is known,
are not related
to cause given
(a).

FATHER

8 FULL NAME

9 RESIDENCE, NO. STREET
CITY OR TOWN STATE

10 COLOR OR RACE

11 AGE AT TIME OF THIS DELIVERY (Years)

12 PLACE OF BIRTH

(City or Town)

(State or country)

13 OCCUPATION

MOTHER

14 MAIDEN NAME Rosemarie Velardo

PRESENT NAME Rosemarie Velardo

15 RESIDENCE, NO. 1061 Saratoga St. STREET
CITY OR TOWN East Boston STATE Mass.

16 COLOR OR RACE W

17 AGE AT TIME OF THIS DELIVERY 22 (Years)

18 PLACE OF BIRTH

Boston

Mass.

(City or Town)

(State or country)

19 INFORMANT Conrad Dampolo

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)

None

(a) How many children are now living?

None

(b) How many children were born alive but are now dead?

None

(c) How many previous fetal deaths of ANY gestation age?

None

21 LENGTH OF PREGNANCY 5 mos.
completed weeks

22 Weight Lb. 2 Oz. 3
OF FETUS (or Grams)

23 WHEN DID FETUS DIE?
Before ☒ During Labor
Labor or Delivery Unknown

24 AUTOPSY
Yes No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Unknown

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

None

26 Holy Cross
Place of Burial or Cremation

Malden
(City or Town)

DATE OF BURIAL

April 3, 1963

27 NAME OF FUNERAL DIRECTOR Vincent Rapino
ADDRESS East Boston, Mass.

Received and filed

April 2, 1963

XX

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 9:25 PM and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Anthony S. Ripa

M.D.

Anthony S. Ripa
(PRINT OR TYPE NAME)

Address 100 Merritt St. 2 St. Andrew Road
East Boston, Mass.

19

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lirianne
(Signature of Agent of Board of Health or other)

Health Officer
(Official Designation)

April 2, 1963
(Date of Issue of Permit)

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 02052

d for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
OR CAUSES
F DEATH

o not enter
re than one
use for each
, (b) and (c)

does not mean
mode of dying,
as heart failure,
etc. It means
cause, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
ng the under-
cause last.

ditions contrib-
o death but not
to the terminal
condition given

IR 11 1963

(52-933404

PLACE OF DEATH

SUFFOLK
(County)
Boston
(City or Town)



BOSTON CITY HOSPITAL

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME Julia (Gannon) Cannon
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WARI) No

(a) Residence, No. 104 Highland Ave. Winthrop, Mass. St. _____
(Usual place of abode) (City or town and State)

Length of stay: In place of death, years, months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 21, 1963 Was a Patient
(Month) (Day) (Year)

4 I HEREBY CERTIFY, December 22, 1962 February 21, 1963
#

I last saw him alive on _____, 19____, death is said to

have occurred on the date stated above, at 5.22p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic Carcinoma of Colon

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Broncho Pneumonia

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signature) Frank C. Gazdagis, M. D.

Frank C. Gazdagis, M.D.

(Address) BOSTON CITY HOSPITAL Date Feb. 22, 1963

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb 23, 1963

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS EAST Boston

Received and filed FEB 27 1963

Charles B. Zmacker
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed

11 If married, widowed, or divorced

HUSBAND of Charles A. Cannon
(or) WIFE of Charles A. Cannon
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 88 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housework
(Kind of work done during most of working life)

14 Industry or Business: OWN Home

15 Social Security No. _____

16 BIRTHPLACE (City, State or country) Newfoundland

17 NAME OF FATHER John M. McCarthy

18 BIRTHPLACE OF FATHER (City, State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Elizabeth Rossiter

20 BIRTHPLACE OF MOTHER (City, State or country) Newfoundland

21 Informant AGNES BINGHAM
1187 Smith St. Providence R. I.
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
F. P. Liaca B 05001
(Signature of Agent of Board of Health or other)
Feb. 22, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



APR 11 1963 AM

ed for burial permit
Board of Health
r its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
(a), (b) and (c)

does not mean
made of dying,
as heart failure,
ia, etc. It means
disease, or compli-
s which caused

ditions, if any,
ch gave rise to
ve cause (a),
ing the under-
ing cause last.

onditions contrib-
to death but not
d to the terminal
condition given
M.C.

220
138
DECLINED BY MEDICAL EXAMINER

PR 11 1966
1 Direction
e use only
ICK Ink.
904
141
x7

X OUT-OF-TOWN

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

64

STANDARD

CERTIFICATE OF DEATH

Registered No. 02302

2 FULL NAME Alice R Jannini
(If deceased is a married, widowed or divorced woman, give also maiden name.)

113 Revere Street

Wimthrop, Mass.

(a) Residence. No.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 27 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That we attended deceased from
February 12 1963 to February 27 1963

er I last saw he alive on February 27 1963, death is said to
have occurred on the date stated above, at 3:30a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BronchopneumoniaDue To Status Post Operation(b) Moore ProsthesisDue To Fractured Hip

(c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NoWhat test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify Chill

(Signature) Charles L. Clay, M. D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address Ass't. Dir., Mass. Gen'l. Hosp. Date Feb. 27, 1963

6 Helen Cross Madaleno
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 2 19637 NAME OF FUNERAL DIRECTOR Jannine SementaADDRESS 324 North St BostonReceived and filed MAR 5 1963Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Ch (Give maiden name of wife in full)

(or) WIFE of Christie Jannini
(Husband's name in full)

12 AGE 56 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation at home
(Kind of work done during most working life)

Industry
or Business:

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts17 NAME OF FATHER James Boylan18 BIRTHPLACE OF FATHER (City) Irish
(State or country)19 MAIDEN NAME OF MOTHER ELISABETH SULLIVAN20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Barbara Carlson
(Address) 113 Revere St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

J. W. Davis
(Signature of Agent of Board of Health or other)

B15433 3-1-63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie
City Registrar

RECEIVED



APR 11 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Boston

(City or Town)

No. New England Center Hospital

STANDARD
 CERTIFICATE OF DEATH

Registered No. 02430

(If death occurred in a hospital or institution,
 St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
 U. S. War Veteran, No.
 if so specify WAR)

2 FULL NAME Louis Biggi
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 27 Bowdoin St., Winthrop, Mass.
 (Usual place of abode)

St. WINTHROP
 (If nonresident, give city or town and State)

18 Hours

Length of stay: In place of death, years, months, days. In place of residence, 7 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 2 1963
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
 March 1, 1963, to March 2, 1963

I last saw him live on March 2, 1963, death is said to
 have occurred on the date stated above, at 3:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia

(b) Due To Chronic congestive

(c) heart failure

OTHER SIGNIFICANT CONDITIONS
 Coronary heart disease

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
 If so, specify

(Signature) Raymon S. Riley, M. D.

Raymon S. Riley

(Print or Type Name)

(Address) N.E. Center Hospital March 2, 1963

6 Old Calvary Boston
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 5, 1963

7 NAME OF FUNERAL DIRECTOR Arthur S. Prorella

ADDRESS 876 Winthrop Ave., Revere

Recorded and filed MAR 6 1963

Charles H. Macchie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
 MARRIED
 WIDOWED
 DIVORCED
 UNKNOWN Single

11 If married, widowed, or divorced
 HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 12-24-1888
 AGE 74 Years 2 Months 8 Days 11 under 24 hours
 Hours Minutes

13 Usual Occupation Retired- Shipper
 (Kind of work done during most working life)

14 Industry or Business

15 Social Security No

16 BIRTHPLACE (City) Boston
 (State or country) Mass.

17 NAME OF FATHER John B. Biggi

18 BIRTHPLACE OF FATHER (City) Boston
 (State or country) Mass., Italy

19 MAIDEN NAME OF MOTHER Theresa Fennochetti

20 BIRTHPLACE OF MOTHER (City) Italy
 (State or country)

21 Informant Mrs. Nellie Christoforo
 (Address)

27 Bowdoin St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
 was filed with me BEFORE the burial or transit permit was issued:

R. B. Sarmon
 (Signature of Agent of Board of Health or other)

15470 3/4/63.
 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

led for burial permit
 Board of Health
 or its Agent.

INSTRUCTIONS
 FOR
 MEDICAL CERTIFICATE

NT OR TYPE
 SE OR CAUSES
 OF DEATH

do not enter
 more than one
 cause for each
 a), (b) and (c)

is does not mean
 mode of dying,
 as heart failure,
 pneumonia, etc. It means
 disease, or compli-
 cations which caused

ditions, if any,
 which gave rise to
 one cause (a),
 being the under-
 lying cause last.

Conditions contrib-
 uted to death but not
 related to the terminal
 disease condition given

Jurisdiction

EXAMINER

waived by
 Medical
 Examiner

APR 11 1963

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



APR 11 1963 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSuffolk
(County)

Chelsea

(City or Town making this return)

PLACE OF DEATH

Chelsea
(City or Town)COPY OF
CERTIFICATE OF DEATH

Registered No. 100 66

No. U.S. Naval Hospital

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

2 FULL NAME Irving Henry Streeter, Jr.

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a WWII
U. S. War Veteran,
if so specify WAR, Kor.(a) Residence. No. 16 Fremont
(Usual place of abode)

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 15 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Mar. 17, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
DOA, 19, to, 19,
I last saw him live on Mar. 18, 1963, death is said to
have occurred on the date stated above, at 11:45p.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart
disease

Due To

(b) disease

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Harold A. Engelke, M. D.

(Address) USNH, Chelsea, Mass. 3/18/63

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Mar. 21, 1963 19

7 NAME OF FUNERAL DIRECTOR Maurice Kirby

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed APR 16 1963 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced

HUSBAND of Elinore M. Perry

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE 52 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Retired U.S. Army
(Kind of work done during most working life)

14 Industry or Business U.S. Army

15 Social Security No. 012-28-4086

16 BIRTHPLACE (City)
(State or country) Fort Warren Boston Har.
Mass.

17 NAME OF FATHER Hugh Streeter

18 BIRTHPLACE OF FATHER (City)
(State or country) Nashua, N.H.

19 MAIDEN NAME OF MOTHER Ella Barraly

20 BIRTHPLACE OF MOTHER (City)
(State or country) Canada21 Informant Mrs. Irving Streeter
(Address)

16 Fremont St., Winthrop, Mass.

MASS COPY

ATTEST: Joseph A. Tyrrell
(Registrar of City or Town where death occurred)

DATE FILED Mar. 20, 1963 19

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... --

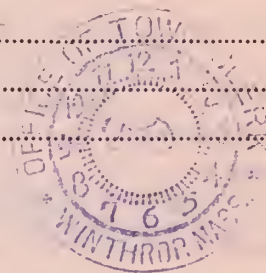
DATE OF DISCHARGE..... --

RANK, RATING MSGT

ORGANIZATION AND OUTFIT U.S. Army

SERVICE NUMBER RA6113435

RECEIVED



APR 16 1963 AM

ed for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
E OR CAUSES
OF DEATH

to not enter
ore than one
use for each
a), (b) and (c)

s does not mean
mode of dying,
as heart failure,
mia, etc. It means
disease, or compli-
s which caused

ditions, if any,
ich gave rise to
e cause (a),
ing the under-
g cause lost.

Conditions contrib-
to death but not
d to the terminal
e condition given
(b).

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return) 67

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)
CONSTANTINOS (or) Charles Spanos

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR.) U.W. I

(a) Residence. No. 4 Brookfield Road St. Winthrop, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....2.....days. In place of residence 32 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 9, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 1961 to April 1963
I last saw him live on April 8, 1963, death is said to have occurred on the date stated above, at 6:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebral Hemorrhage 2 days
(b) Due To Atherosclerosis 2 yrs
(c) Hypertension 2 yrs

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS None.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 4/9/1963

6 WINTHROP CEMETERY - WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 13, 1963

7 NAME OF FUNERAL DIRECTOR Paul P. Dimock
ADDRESS 336 BROADWAY - CAMBRIDGE
Received and filed APR 11 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN MARRIED

11 If married, widowed or divorced HUSBAND of CHRISOULA LIMBEROPOULOS
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 70 Years 11 Months Days If under 24 hours Hours Minutes

13 Usual Occupation: GROCERY CLERK
(Kind of work done during most working life)

14 Industry or Business: RETIRED

15 Social Security No. 027-28-4816

16 BIRTHPLACE (City) GREECE
(State or country)

PARENTS

17 NAME OF FATHER JOHN SPANOS

18 BIRTHPLACE OF FATHER (City) GREECE
(State or country)

19 MAIDEN NAME OF MOTHER MARY MOU TOUGLI

20 BIRTHPLACE OF MOTHER (City) GREECE
(State or country)

21 Informant (Address) CHRISOULA SPANOS
4 - BROOKFIELD R. D WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Health Officer (Signature of Agent of Board of Health or other) April 11, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

JUNE 27 1918

DATE OF DISCHARGE.....

NOV 28 1918

RANK, RATING

P.V.T.

ORGANIZATION AND OUTFIT.....

ARMY

SERVICE NUMBER.....

366 4433

RECEIVED

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

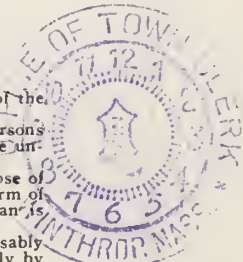
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 68

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No.

47 Shirley Street

Angelina Gizzi

2 FULL NAME

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

230 Everett

(a) Residence, No.

(Usual place of abode)

St.

East Boston

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 13, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw him alive on 19....., death is said to have occurred on the date stated above, at 6:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death Presumably due to

(b) Due To natural causes, probably acute cerebrovascular

(c) Due To occlusion based on medical history

OTHER SIGNIFICANT CONDITIONS
Winthrop Board of Health
Charles Liberman M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) CHARLES LIBERMAN M.D.

(PRINT OR TYPE SIGNATURE)

(Address) Winthrop Date 4/18/1963

6 Holy Cross Cemetery Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 17, 1963

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed APR 17 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED widowed or DIVORCED

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Thomas Gizzi (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years.....Months.....Days If under 24 hoursHours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Italy (State or country)

17 NAME OF FATHER Louis Licciardi

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Maria (unknown)

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant (Address) Helen Tiano (daughter) 47 Shirley St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) April 16-63 (Date of Issue of Permit)

M R-301A

INSTRUCTIONS
FOR
L CERTIFICATE

n giving
OF DEATH

not enter
e than one
e for each
, (b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

tions, if any,
gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
o death but not
to the terminal
condition given

Chapter 137,
of 1954, requires
cians to print or
the cause or
s of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

PLACE OF DEATH

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

Registered No. 69

No. Mayflower Nursing Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)2 FULL NAME Samuel Nager
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran. *W 6*
if so specify WAR)(a) Residence. No. 39 Grovers Ave.
(Usual place of abode)St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 4 years months days. In place of residence 4 years months days.

INSTRUCTIONS
FOR
CERTIFICATEa giving
OF DEATHnot enter
than one
for each
(b) and (c)does not mean
of dying,
heart failure,
etc. It means
cause, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
certificates.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 13 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
MARCH 15, 1958, to APRIL 13, 1963
I last saw him alive on APRIL 11, 1963, death is said to
have occurred on the date stated above, at 8 22 P.m.INTERVAL
BETWEEN
ONSET AND
DEATH
15 YRS

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERALIZED ARTERIO-
SCLEROSIS

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS CHRONIC BRONCHITIS
5 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Joseph J. Palmer, M.D., M. D.

(Address) 202 PRESIDENT AVE Date 4/13 1963
Beverly

6 Tifereth Israel Cem. Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 14 1963

7 NAME OF FUNERAL DIRECTOR Murray Goldman
ADDRESS 174 Ferry St. Malden

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED divorced
or DIVORCED10a If married, widowed or divorced
HUSBAND of Ida Goldstein
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 74 Years Months Days If under 24 hours
AGE Hours Minutes13 Usual Occupation: painter
(Kind of work done during most of working life)

14 Industry or Business: retired

15 Social Security No. none

16 BIRTHPLACE (City) Minsk, Russia
(State or country)

17 NAME OF FATHER Samuel

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Fannie (unknown)

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant Irving Nager-brother
(Address) 29 Nichols St. Everett.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Signature of Agent of Board of Health or other
Health Officer (Official Designation)
(Date of Issue of Permit) April 15, 1963

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . . General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death. Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation. If the statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only employment was that of home housework, write housework. For a person engaged in domestic service, for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

INSTRUCTIONS
FOR
CERTIFICATE

In giving
OF DEATH

do not enter
more than one
cause for each
a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
mia, etc. It means
disease, or compli-
s which caused

Conditions, if any,
which gave rise to
ove cause (a),
ling the under-
ng cause lost.

Conditions contrib-
to death but not
d to the terminol
ie condition given

Chapter 137,
of 1954, requires
ans to print or
the cause or
s of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 20 Centre St.



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 70

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Catherine F. Crosby.

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, NO
if so specify WAR)

(a) Residence. No. 20 Centre St.
(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 5 years.....months.....days. In place of residence 5 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 17 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Feb 1963, to April 17 1963
I last saw her alive on April 17 1963, death is said to
have occurred on the date stated above, at 11:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchial Pneumonia

Due To Cerebral Vascular
(b) accident

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Nathaniel P. Danoff, M. D.
Nathaniel P. Danoff

(PRINT OR TYPE SIGNATURE)
(Address) 37 Princeton St. Date April 18 1963

6 Place of Burial or Cremation Holy Cross Malden.
(City or Town)
DATE OF BURIAL April 20 1963

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath.
ADDRESS 325 Chelsea St. East Boston.

Received and filed APR 23 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Single
WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Sorter (retired)
(Kind of work done during most of working life)

14 Industry or Business: Retired Laundry
Off 05 9490

15 Social Security No. Chelsea
Mass.

16 BIRTHPLACE (City) (State or country)

17 NAME OF FATHER Michael Crosby

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Rose Ann McKimmon

20 BIRTHPLACE OF MOTHER (City) Conn.
(State or country)

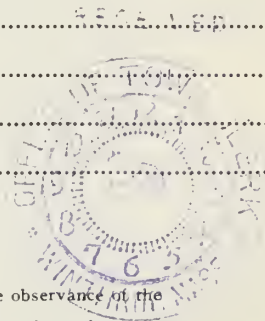
21 Informant Ann Crosby (Sister)
(Address) 20 Centre St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Signature of Agent of Board of Health or other

Health Officer April 22, 1963
(Official Designation) (Date of Issue of Permit)

T ✓

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

not enter
more than one
cause for each
(a), (b) and (c)

does not mean
mode of dying,
heart failure,
a, etc. It means
cause, or compli-
which caused

conditions, if any,
which gave rise to
the cause (a),
the under-
cause last.

conditions contrib-
to death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. 104 Highland Ave
Mounts Nursing Home2 FULL NAME Ellen E. Horrigan
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 34 A Bunker Hill St. St. Charlestown, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 4 years.....months.....days. In place of residence 86 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 19, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
May 9, 1958, to April 19, 1963
I last saw her alive on April 15, 1963, death is said to
have occurred on the date stated above, at 8:30a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction 1 hr.

(b) Arteriosclerotic HD 5 yrs

(c) Generalized arteriosclerosis 8 yrs

OTHER SIGNIFICANT CONDITIONS Chronic bronchitis &
pulmonary emphysema 3 yrsWas autopsy performed? no
What test confirmed diagnosis? clinical & lab5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) M. Traunstein Jr., M.D.

(Print or Type Name) M. Traunstein Jr., M.D.

(Address) 73 Bartlett Rd. Date 4-20 1963

6 Holy Cross Malden, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 22, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed APR 22 1963

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 71

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Single
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 90 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: At Home
(Kind of work done during most working life)14 Industry
or Business:

15 Social Security No. None

16 BIRTHPLACE (City) Charlestown
(State or country) Mass

17 NAME OF FATHER Jeremiah Horrigan

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Ellen Reardon

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Norman Horrigan
(Address) 150 Washington Ave., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:(Signature of Agent of Board of Health or other)
Health Officer (Official Designation)

(Date of Issue of Permit) April 22, 1963

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED



APR 22 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. Mount's Nursing Home

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 72

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, No
(if so specify WAR)

2 FULL NAME Alexander STUNDZIO

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 32 Spruce St., Chelsea, Mass. St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 2 years months days. In place of residence years months days.

INSTRUCTIONS
FOR
CERTIFICATEIn giving
OF DEATHdo not enter
more than one
cause for each
(a), (b) and (c)does not mean
mode of dying,
as heart failure,
etc. It means
cause, or compli-
cation which causedconditions, if any,
which gave rise to
the cause (a),
being the under-
lying cause last.conditions contrib-
uting to death but not
the terminal
condition givenChapter 137,
of 1954, requires
plans to print or
the cause or
of death on
certificates, and
er 48, Acts of
requires Physi-
to print or type
under signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 19 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
, 19, to, 19,I last saw him alive on , 19, death is said to
have occurred on the date stated above, at 7:30 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

natural causes, probably
a cerebrovascular occlusion(b) on basis of past history.
(c) Winthrop Board of Health.

OTHER SIGNIFICANT CONDITIONS Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) CHARLES LIBERMAN, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP Date 4/19/1963

6 Holy Cross Cemetery Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Monday, April 22, 1963

7 NAME OF FUNERAL DIRECTOR CHESTER V. ZAKSHESKI

ADDRESS 79 Broadway - Chelsea

Received and filed APR 22 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED
or DIVORCED10a If married, widowed, or divorced
HUSBAND of Margaret (Balon) GASKA
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Laborer
(Kind of work done during most of working life)

14 Industry or Business: Bldg.-Wrecking trade

15 Social Security No. 015-18-3080

16 BIRTHPLACE (City) Poland
(State or country)

17 NAME OF FATHER cannot be learned

18 BIRTHPLACE OF FATHER (City) Poland
(State or country)

19 MAIDEN NAME OF MOTHER cannot be learned

20 BIRTHPLACE OF MOTHER (City) Poland
(State or country)21 Informant Laurel Shaughnessey
(Address) 173 Shurtleff St. - ChelseaI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued.Signature of Agent of Board of Health or other
Death Office April 22, 1963
(Official Designation) (Date of Issue of Permit)

RECEIVED



SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

APR 22 1963 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
ode of dying,
heart failure,
, etc. It means
case, or compli-
which caused

ions, if any,
gave rise to
cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 73

No. 16 A. Wheelock Street

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Kenneth Morrill Godfrey

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.(a) Residence, No. 16A. Wheelock Street
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 8 years, 40 months, 40 days. In place of residence 40 months, 40 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
April 16, 1963, to April 20, 1963I last saw him live on April 19, 1963, death is said to
have occurred on the date stated above, at 2:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

(b) Generalized

(c) Chronic Valvular Heart Disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) J. J. Godfrey, M. D.

(Print or Type Name)

(Address) 194 Washington St. Date 7/10/63

6 Winthrop Cemetery, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 23, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed APR 23 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) married

11 If married, widowed, or divorced HUSBAND of Vera Thorne Littlefield
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 67 Years 10 Months 13 Days If under 24 hours Hours Minutes

13 Usual Occupation retired guard
(Kind of work done during most working life)

14 Industry or Business Mass. Institute of Tech.

15 Social Security No. 010-09-8908

16 BIRTHPLACE (City) Wakefield Mass.

17 NAME OF FATHER Frank Warren Godfrey

18 BIRTHPLACE OF FATHER (City) Wakefield Mass.

19 MAIDEN NAME OF MOTHER Alice Morrill

20 BIRTHPLACE OF MOTHER (City) Melrose Mass.

21 Informant Mrs. Kenneth M. Godfrey
(Address) 16A. Wheelock St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph B. L. (Signature of Agent of Board of Health or other)

Health Officer April 23 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

led for burial permit
Board of Health
or its Agent.

N. B. - WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932605

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 74

No. 390 Winthrop St., Winthrop

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME DONALD McDUGALL
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

390 Winthrop Street,

Winthrop, Massachusetts

(a) Residence. No. (Usual place of abode) St. (If nonresident, give city or town and State)

Length of stay: In place of death 30 years.....months.....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

PORTAL CIRRHOSIS OF LIVER

(77)

5 Accident, suicide, or homicide (specify)

Date and hour of injury19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did
Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?

(Specify type of place)

Manner of
Injury

(How did injury occur?)

Nature of
Injury

While at work? Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.

(Print or Type Name)

(Address) Boston Date 19.....

7 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 22, 1963

8 NAME OF FUNERAL DIRECTOR Howard S. Reynolds
Winthrop, Mass

Received and filed APR 22 1963 19.....

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)
MARRIED Single
WIDOWED
DIVORCED
UNKNOWN

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 50 Years 7 Months 12 Days If under 24 hours
Hours Minutes

14 Usual Occupation: Radio (Kind of work done during most of working life)

15 Industry or Business: Repairs

16 Social Security No. 024-12-1242

17 BIRTHPLACE (City) East Boston
(State or country) Mass

18 NAME OF FATHER William McDougall

19 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass

20 MAIDEN NAME OF MOTHER Mary Hammerer

21 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

22 Informant Elizabeth Bradford
(Address) 8 Surfside Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni (S)
(Signature of Agent of Board of Health or other)

Health Officer
(Official Designation)

April 22, 1963
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FORM R-301

ed for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
na, etc. It means
disease, or compli-
cations which caused

ditions, if any,
which gave rise to
the cause (a),
the underlying
cause last.

Conditions contrib-
to death but not
to the terminal
condition given

7M

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. 26 BEACON ST WINTHROP

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return,

STANDARD
CERTIFICATE OF DEATH

Registered No. 75

{ If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)
PHYSICIAN - IMPORTANT

2 FULL NAME WILFRED S JOHNSON

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a
U. S. War Veteran, WW 2
if so specify WAR)

(a) Residence. No. 26 BEACON ST
(Usual place of abode)S. WINTHROP MASS
(City or town and State)

Length of stay: In place of death 5 years months days. In place of residence 45 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 21 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
APRIL 24 1959 to APRIL 21 1963I last saw him live on APRIL 1 1963 death is said to
have occurred on the date stated above, at 11:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL
INFARCTION

(b) ARTERIO-SCLEROTIC HEART DISEASE 4 YRS

(c) GENERAL ATHEROSCLEROSIS 4 YRS

OTHER SIGNIFICANT CONDITIONS 3 PREVIOUS INFARCTIONS 4 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Myron N. King, M. D.

MYRON N. KING
(Print or Type Name)

(Address) 222 PLEASANT ST WINTHROP MASS Date APRIL 23 1963

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 24 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed APR 23 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
MALE	WHITE	DIVORCED

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 53 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: LABORER (RETIRED)
(Kind of work done during most of working life)

14 Industry or Business: TOWN OF WINTHROP

15 Social Security No.
16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

17 NAME OF FATHER ERICK W JOHNSON

18 BIRTHPLACE OF FATHER (City) EAST BOSTON
(State or country) MASS

19 MAIDEN NAME OF MOTHER ALICE L SCOTT

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS

21 Informant FREDERICK LAIDLAW

(Address) 141 COTTAGE PK RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph S. Laidlaw
(Signature of Agent of Board of Health or other)
Health Officer (Official Designation) Apr 23 1963 (Date of Issue of Permit)

A TRUE COPY ATTEST:

V. L. V.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....MARCH 21 1941
DATE OF DISCHARGE.....OCT 4 1943
RANK, RATING.....CPL.
ORGANIZATION AND OUTFIT.....ARMY
SERVICE NUMBER.....310 32389

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
ie for each
, (b) and (c)

does not mean
ode of dying,
heart failure,
, etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

11 C.

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 76

No. Winthrop Community Hospital (If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Margaret (Reid) Ramsey
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 27 Vine Avenue
(Usual place of abode) St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 21 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
4/20 1963, to 4/21 1963

I last saw him alive on 4/21 1963, death is said to
have occurred on the date stated above, at 11:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCT 1 1/2 days

Due To (b) GENERAL ARTERIO-SCLEROSIS SYNS

Due To (c)

OTHER SIGNIFICANT CONDITIONS SENILE PSYCHOSIS SYNS

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & EEG

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING
(Print or Type Name)

(Address) 222 Pleasant St. Date 4/21 1963
Winthrop Winthrop

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 21 1963

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop Mass

Received and filed APR 23 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Walter D. Ramsey
(Husband's name in full)

12 AGE 77 Years 5 Months 10 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) Scotland
(State or country)

17 NAME OF FATHER John Reid

18 BIRTHPLACE OF FATHER (City) Scotland
(State or country)

19 MAIDEN NAME OF MOTHER Jannett Bain

20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)

21 Informant (Address) John P. Reid
1986 Commonwealth Ave. Boston, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Serjann (31)
(Signature of Agent of Board of Health or other)
Health Officer (Official Designation) April 23 1963
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



RULES OF PRACTICE

APR 23 1963 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
L CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
, (b) and (c)

does not mean
ode of dying,
heart failure,
etc. It means
ase, or compli-
which caused

itions, if any,
gave rise to
cause (a),
g the under-
cause last.

nditions contrib-
o death but not
to the terminal
condition given

M.C.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 77

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Louise Madeline (Fopiano) Ayer
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

(a) Residence, No. 176 Woodside Avenue St. Winthrop Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 7 Days In place of residence, 53 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 23, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
July 2, 1956, to April 23, 1963

I last saw her live on Apr. 22, 1963, death is said to
have occurred on the date stated above, at 2:09 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive cerebral hemorrhage 18 hrs

Due To Arteriosclerotic and
(b) hypertensive heart disease 8 yrs.

Due To Generalized arterio-
(c) sclerosis 10 yrs.

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Clinical & labora-
tory

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) M. Traunstein, Jr., M. D.

M. Traunstein, Jr., M. D.

(Print or Type Name)

(Address) 73 Bartlett Rd. Date: Apr. 23, 1963

Winthrop 52, Mass.

6 Mt. Calvary Cemetery Boston, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 25, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass

Received and filed APR 24 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)
WIFE of Albert Leon Ayer

12 AGE 78 Years 2 Months 3 Days If under 24 hours
Hours Minutes

13 Usual Occupation: housework
(Kind of work done during most working life)

14 Industry or Business: own home

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Stephen Fopiano

18 BIRTHPLACE OF FATHER (City) Genoa
(State or country) Italy

19 MAIDEN NAME OF MOTHER unable to ascertain

20 BIRTHPLACE OF MOTHER (City) " " (State or country) " "

21 Informant John L. Ayer
(Address) 176 Woodside Avenue

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)

No. Guardian Hospital

2 FULL NAME

Mary Finneran

(If deceased is a married, widowed or divorced woman, give also maiden name.)

46 Washington Ave.

(a) Residence. No. (Usual place of abode)

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Registered No.

584-178

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

April 24, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY. That I attended deceased from April 23, 63, to April 24, 1963

I last saw him on April 24, 1963 death is said to have occurred on the date stated above, at 5:10p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic Cancer of Breast right side

(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) James L. Crooker, M. D.

(Address) 386 Broadway Somerville Date: Apr. 24, 63

6 New Calvary Cem. Boston

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 29, 1963

7 NAME OF FUNERAL DIRECTOR P.E. Murray Funeral Service

ADDRESS 54 Roxbury St. Roxbury

Received and filed MAY 2 - 1963

(Registrar of City or Town where deceased resided)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Cambridge

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

584-178

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

(Was deceased a U. S. War Veteran, if so specify WAR) No

Winthrop, Mass.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widowed

11 If married, widowed, or divorced

HUSBAND of

(or) WIFE of Joseph P. Finneran (Give maiden name of wife in full)

(Husband's name in full)

12 AGE

74

Years.....Months.....Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation:

Nursing Home

(Kind of work done during most working life)

14 Industry

or Business:

Nursing Home

15 Social Security No.

Boston

16 BIRTHPLACE (City)

Mass.

(State or country)

PARENTS

17 NAME OF FATHER

Timothy Glennon

18 BIRTHPLACE OF FATHER (City)

Boston

(State or country)

Mass.

19 MAIDEN NAME OF MOTHER

Anna Kelly

20 BIRTHPLACE OF MOTHER (City)

Boston

(State or country)

Mass.

21 Informant (Address)

Leo P. Finneran (son)

11 Sanborn Ave. W. Roxbury

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

Apr. 26,

1963

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



MAY 2 1963 AM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
cause, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. ~~1511~~

1 PLACE OF DEATH Suffolk (County)
Winthrop (City or Town)

No. 52 Lincoln St. (Winthrop) (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James E Phillips
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 61 Vinal St.
(Usual place of abode) Revere Mass
(If nonresident, give city or town and State)

Length of stay: In place of death, 1 years, 4 months, 4 days. In place of residence, 1 years, 4 months, 4 days.

MEDICAL CERTIFICATE OF DEATH			PERSONAL AND STATISTICAL PARTICULARS		
3 DATE OF DEATH <u>April 24, 1963</u> (Month) (Day) (Year)	4 I HEREBY CERTIFY, That I attended deceased from <u>Mar 11, 1963</u> to <u>April 24, 1963</u> I last saw <u>him</u> alive on <u>April 24, 1963</u> death is said to have occurred on the date stated above, at <u>9 P.M.</u>		8 SEX <u>male</u>	9 COLOR <u>white</u>	10 SINGLE (write the word) <u>MARRIED</u> WIDOWED DIVORCED UNKNOWN <u>married</u>
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4/22/63</u>		11 If married, widowed, or divorced HUSBAND of <u>JULIA CERCHIONE</u> (Give maiden name of wife in full)		
Due To (b) <u>Cerebral Thrombosis</u>	<u>3/21/69</u>		(or) WIFE of _____ (Husband's name in full)		
Due To (c) <u>Acute Cardiac Decompenation</u>	<u>Mar 11/63</u>		12 AGE <u>82</u> Years _____ Months _____ Days _____ If under 24 hours _____ Hours _____ Minutes _____		
OTHER SIGNIFICANT CONDITIONS <u>Periculous Anemia</u>	<u>1958</u>		13 Usual Occupation: <u>Shoe Industry</u> (Kind of work done during most working life)		
Was autopsy performed? <u>no</u>	What test confirmed diagnosis? <u>Clinical exam</u>		14 Industry or Business: <u>Shoe Industry</u>		
5 Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify _____			15 Social Security No. <u>013-03-6017</u>		
(Signature) <u>Louis E Schraffer</u> , M. D. <u>LOUIS E. SCHRAFFER M.D.</u> (Print or Type Name)	(Address) <u>143 E. 1st St. Boston</u> Date <u>April 24, 1963</u>		16 BIRTHPLACE (City) <u>Boston</u> (State or country) <u>MASS</u>		
6 <u>HOLY CROSS CEMETERY</u> <u>MAIDEN</u> Place of Burial or Cremation (City or Town)	DATE OF BURIAL <u>April 29</u> 19 <u>63</u>		17 NAME OF FATHER <u>FRANK PHILLIPS</u>		
7 NAME OF FUNERAL DIRECTOR <u>JOSEPH A LANGONE III</u>	ADDRESS <u>58 MERRIMAC ST BOSTON</u>		18 BIRTHPLACE OF FATHER (City) <u>MEDWAY</u> (State or country) <u>MASS</u>		
Received and filed <u>MAY 2 - 1963</u>			19 MAIDEN NAME OF MOTHER <u>SARAH GANON</u>		
			20 BIRTHPLACE OF MOTHER (City) <u>IRE LAND</u> (State or country)		
			21 Informant <u>JULIA PHILLIPS WIFE</u> (Address) <u>61 VINAL ST REVERE MASS</u>		
			I hereby certify that this is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.		
			By <u>Reverend J. J. Sullivan</u> (Agent of Board of Health or other)		
			Health Officer <u>4/26/63</u> (Date of Issue of Permit)		

(Registrar)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

T OR TYPE
OR CAUSES
OF DEATH

not enter
more than one
cause for each
(b) and (c)

does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
ng the under-
cause last.

conditions contrib-
to death but not
to the terminal
condition given

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 80

WINTHROP COMMUNITY HOSP. (If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME POSSIDONIO B. ALMEIDA (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) WWII

(a) Residence. No. 66 TRENTON St. EAST BOSTON MASS
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, years 17, months 40, days. In place of residence, years 40, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 26 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1956, to April 26, 1963.
I last saw him live on April 26, 1963 death is said to have occurred on the date stated above, at 6 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral thrombosis 12 days

Due To (b) arteriosclerosis 15-20 yrs

Due To (c) Diabetes mellitus 15-20 yrs

OTHER SIGNIFICANT CONDITIONS Coronary thrombosis 12 days

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) H. B. Greenfield, M. D.

447 CH (Print or Type Name)

(Address) WINTHROP MASS Date 4-26-1963

HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 29 1963

7 NAME OF FUNERAL DIRECTOR DIPIETRO VAZZA

ADDRESS 11 HENRY ST EAST BOSTON

Received and filed APR 30 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED SINGLE UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 65 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation LONGSHOREMAN (Kind of work done during most working life)

14 Industry or Business SUGAR REFINERY

15 Social Security No. 013-05-5838

16 BIRTHPLACE (City) PORTUGAL (State or country)

17 NAME OF FATHER MANUEL ALMEIDA

18 BIRTHPLACE OF FATHER (City) PORTUGAL (State or country)

19 MAIDEN NAME OF MOTHER AUGUSTA GRACE

20 BIRTHPLACE OF MOTHER (City) PORTUGAL (State or country)

21 Informant FRANCISCO MARTINS (Address) 21 EUTAW STREET EAST BOSTON MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siranni (B) (Signature of Agent of Board of Health or other)

Health Officer April 29, 1963 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE SEPT. 2, 1942
DATE OF DISCHARGE SEPT. 29, 1944
RANK, RATING PRIVATE
ORGANIZATION AND OUTFIT U.S. ARMY ENLISTED RESERVE CO.
SERVICE NUMBER 31166020

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M. 10-61-931673

PLACE OF DEATH

Suffolk
(County)Chelsea
(City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 840 81

No. Soldiers' Home Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Walter A. Smith

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a WWI
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 14 Townsend
(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay in place of death, 1 year 1 months 20 days. In place of residence, 5 years 1 months 1 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 26, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Mar. 6, 63, to April 26, 1963

I last saw him alive on April 26, 63, death is said to have occurred on the date stated above, 9:30p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of prostate with

Due To Widespread metastasis to
(b) lungs and bones yrs.Due To
(c)OTHER
SIGNIFICANT
CONDITIONSINTERVAL
BETWEEN
ONSET AND
DEATH

Was autopsy performed? no

What test confirmed diagnosis clinical & labs. findings

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Sofik Abdulhayoglu, M. D.

(Address) Soldiers' Home Apr. 26, 63

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 30, 1963

7 NAME OF FUNERAL DIRECTOR Wm. H. McKenna

ADDRESS Somerville, Mass.

Received and filed 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed

11 If married, widowed, or divorced

HUSBAND of Nellie E. Conway
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 72 Years 2 Months 0 Days If under 24 hours
Hours Minutes13 Usual Occupation: Retired Fire Capt.
(Kind of work done during most working life)

14 Industry or Business: Fire Dept.

15 Social Security No. 018-20-0822

16 BIRTHPLACE (City)
(State or country) Somerville, Mass.

17 NAME OF FATHER William H.

18 BIRTHPLACE OF FATHER (City)
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Minnie E. Wile

20 BIRTHPLACE OF MOTHER (City)
(State or country) Massachusetts21 Informant Hospital Records
(Address)

Soldiers' Home Hospital

A TRUE COPY

ATTEST: Joseph A. Tyrrell
(Registrar of City or Town where death occurred)

DATE FILED April 26, 1963

V. M.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 5/26/18

DATE OF DISCHARGE..... 7/3/19

RANK, RATING Sgt.

ORGANIZATION AND OUTFIT U.S.A. Motor Truck Co. 473 Motor Supply Train 4

SERVICE NUMBER..... 319 1918

MAY - 8 1963 AH

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATHRegistered No. ~~245~~

82

PLACE OF DEATH

Suffolk
(County)Chelsea
(City or Town)No. Soldiers' Home Hospital(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Paul Vincent Marr

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a **VWI**
U. S. War Veteran,
if so, specify WAR.)(a) Residence. No. 4 Elm Wood Court
(Usual place of abode)// St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death, hospital years 11 months 28 days. In place of residence, years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHApril 30, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

May 3, 62, to April 30, 1963
I last saw him alive on April 30, 1963, death is said to
have occurred on the date stated above, at 11:40 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Ulcerative colitis. Long yrs.Due To standing ileostomy;(b) extensive colon resections;Due To abdominoperineal resection yrs.

(c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? noWhat test confirmed diagnosis? x-ray-surgical5 Was disease or injury in any way related to occupation of deceased? no
If so, specify(Signed) Charles D. Kemos, M. D.(Address) Soldiers' Home Da 5/1/63 1963
Chelsea, Mass.6 Calvary Cem., Portland, Me.
Place of Burial or Cremation (City or Town)DATE OF BURIAL May 3, 1963 19637 NAME OF
FUNERAL DIRECTOR O'Malley Funeral HomeADDRESS 79 Atlantic St., Winthrop, Mass.Received and filed May 1, 1963 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MaleWhiteMARRIED
WIDOWED
DIVORCED
UNKNOWN
widowed

11 If married, widowed, or divorced

HUSBAND of Nellie Keller
(Give maiden name of wife in full)(or) WIFE of Nellie Keller
(Husband's name in full)

12

AGE 73 Years 10 Months 1 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Kitchen Man
(Kind of work done during most working life)

14 Industry

or Business: Restaurant Work15 Social Security No. 004-01-8180

16 BIRTHPLACE (City)

(State or country) Portland, Me.

17 NAME OF

FATHER John F. Marr

18 BIRTHPLACE OF

FATHER (City) Maine
(State or country)

19 MAIDEN NAME

OF MOTHER Delia M. Curran

20 BIRTHPLACE OF

MOTHER (City) Maine
(State or country)

21 Informant

(Address)

Hospital Record OfficeSoldiers' Home Hospital

TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

May 1, 1963 1963WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....7/25/18
DATE OF DISCHARGE.....1/21/19
RANK, RATING.....Private 1/c Co.B
ORGANIZATION AND OUTFIT.....34th M.G.B.N.
SERVICE NUMBER.....
.....

MAY - 31 1933 AM

filed for burial permit
by Board of Health
or its agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N.B. - WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, § 6, 20; Chap. 46, § 9, 10; Chap. 114, § 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

OUT - OF TOWN

(City or Town making this return)

Registered No. 03386

No. 27 Park Drive.

2 FULL NAME JOSEPH A FRASER
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, WW II
{ if so specify WAR)

(a) Residence, No. 27 Park Drive St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence 10 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH On or about March 19, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)

Atherosclerotic heart disease.

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did
Injury occur?
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?
(Specify type of place)

Manner of
Injury
(How did injury occur?)

Nature of
Injury

While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

If

(Signed) Michael A. Diongo, M.D.
(Print or Type Name)

(Address) Boston, Mass. Date 3/24/63

7 PLACE OF BURIAL OR CREMATION WINTHROP
(City or Town)

DATE OF BURIAL MARCH 24 1963

8 NAME OF FUNERAL DIRECTOR MURRICE W. WIRBY

ADDRESS WINTHROP

Received and filed Charles H. Baker, 1963

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX MALE 10 COLOR WHITE 11 SINGLE * (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN DIVORCED

12 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 50 Years..... Months..... Days..... If under 24 hours
Hours..... Minutes

15 Usual Occupation SPOONER
(Kind of work done during most of working life)

16 Industry or Business WOOD

17 Social Security No.

18 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

19 NAME OF FATHER JOSEPH FRASER.

20 BIRTHPLACE OF FATHER (City) EAST BOSTON
(State or country) MASS

21 MAIDEN NAME OF MOTHER MARY BOWIE

22 BIRTHPLACE OF MOTHER (City) EAST BOSTON
(State or country) MASS.

23 Informant JAMES FRASER
(Address) 105 PINE RIDGE RD READING

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) BOS923 (Date of Issue of Permit) 3-25-63

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



MAY 14 1963 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWrentham
(City or Town making this return)

PLACE OF DEATH

Norfolk

(County)

Wrentham

(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No. 35

No. The Wrentham State School

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME. Suzanne Arnoldson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR, No

(a) Residence. No. 45 Perkins Street
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death, 22 years, 11 months, 27 days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 31 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from March 31, 19 47, to March 31, 19 63
I last saw him alive on March 31, 19 63, death is said to have occurred on the date stated above, at 3:40 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia (Left) months
(b) Due To Pulmonary abscess (L.U.L.) months
(c) Due To Circulatory Malformations congenital

OTHER SIGNIFICANT CONDITIONS Cyanosis

Was autopsy performed? Yes
What test confirmed diagnosis? Clinical & Autopsy5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Wiggin L. Merrill, M. D.

(Address) Wrentham, Mass. Date Apr. 1 19 63

6 Mt. Auburn Crematory, Cambridge, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 3, 19 63

7 NAME OF FUNERAL DIRECTOR Short & Williamson, Inc.

ADDRESS 52 Trapelo Road, Belmont, Mass.

Received and filed MAY 29 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Single DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 AGE 32 Years, 9 Months, 12 Days If under 24 hours Hours Minutes

13 Usual Occupation Patient at the Wrentham State School
(Kind of work done during most working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) Boston (State or country) Massachusetts

PARENTS 17 NAME OF FATHER Frank Arnoldson

18 BIRTHPLACE OF FATHER (City) Waltham (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Doris O'Neil

20 BIRTHPLACE OF MOTHER (City) South Hadley (State or country) Massachusetts

21 Informant (Address) Wrentham State School Wrentham, Massachusetts

A TRUE COPY
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED April 3, 1963

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



MAY 29 1963 AM

INSTRUCTIONS
FOR
VITAL CERTIFICATE

In giving
STATE OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
etc. It means
disease, or compli-
cations which caused

ditions, if any,
which gave rise to
the cause (a),
being the under-
lying cause last.

conditions contrib-
uted to death but not
led to the terminal
condition given

296
166

ote: Chapter 17,
of 1934 requires
physicians to print or
the cause or
ses of death on
th certificates, and
pter 48, Acts of
9, requires Physi-
s to print or type
the under signature.
Y 14 1963

use only

ACK Ink.

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL

2 FULL NAME Helen W Tulin

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 58 Birch Road, Winthrop, Massachusetts

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 1. 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY. That deceased died on March 22, 1963, to April 1, 1963.

Last saw her alive on April 1, 1963, death is said to

have occurred on the date stated above, at 7:50am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Intraperitoneal Hemorrhage

Due To

(b) Hemorrhagic Diathesis

Due To Idiopathic Thrombocyto-
(c) penic Purpura

OTHER SIGNIFICANT CONDITIONS Obesity

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Charles L. Clay, M.D.

(Print or Type Name)

(Address) Asst. Dir. Mass. Gen. Hosp. Date April 1, 1963

6 Staro Konstandine (Lebanon) W. Roxbury

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL April 2, 1963

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 120 Harvard Street, Brookline

Received and filed APR 2 1963

Charles H. Mack

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

001-15-TOWN

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 13665

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 CITIZEN
OF U.S.

11 SINGLE
MARRIED
WIDOWED
DIVORCED
UNKNOWN

female

white

YES ☒ NO ☐

11a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Mischa Tulin

(Husband's name in full)

12 DATE OF BIRTH

13

AGE 55 Years.....Months.....Days

If under 24 hours

.....Hours.....Minutes

14 Usual

Occupation: Piano Teacher

(Kind of work done during most of working life)

15 Industry

or Business:

16 Social Security No.

17 BIRTHPLACE (City)

(State or country)

New York

Edin N.Y.

18 NAME OF

FATHER

Joshua H. Gordon

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Russia

20 MAIDEN NAME

OF MOTHER

Clara R. Dinn

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

Germany

22

Informant

(Address)

87 Barry I. Tulin

58 Birch Road, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar



MAY 14 1963 AM

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
 CERTIFICATE OF DEATH

Registered No. 03750

(If death occurred in a hospital or institution,
 St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Albert L Day
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
 U. S. War Veteran, no
 if so specify WAR)

64 Lincoln Street
 (a) Residence. No. _____
 (Usual place of abode)

Winthrop, Mass.
 (If nonresident, give city or town and State)

Length of stay: In place of death, years.....months.....days. In place of residence, 2 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 2 1963
 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased, from
March 28, 1963, to April 2, 1963

I last saw him live on April 2, 1963 death is said to
 have occurred on the date stated above, at 4:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary EmphysemaINTERVAL
BETWEEN
ONSET AND
DEATHunk yrs

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSCor Pulmonaleunk yrsWas autopsy performed? YesWhat test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
 If so, specify Chilley

(Signature) Chilley, M. D.

Charles L. Clay, M.D.

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Apr. 2 1963

6 Winthrop Cemetery, Winthrop
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 4 19637 NAME OF FUNERAL DIRECTOR Ernest P. CaggianoADDRESS 147 Winthrop St. WinthropReceived and filed APR 4 1963Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR white 10 SINGLE (write the word)
 MARRIED married
 WIDOWED
 DIVORCED
 UNKNOWN

11 If married, widowed or divorced
 HUSBAND of Elgie Mackie
 (Give maiden name of wife in full)

(or) WIFE of _____
 (Husband's name in full)

AGE 82 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: Railroad worker
 (Kind of work done during most working life)

14 Industry or Business: Railroad

15 Social Security No. _____

16 BIRTHPLACE (City) New Hampshire
 (State or country)

17 NAME OF FATHER Information Unavailable

18 BIRTHPLACE OF FATHER (City) Information Unavailable
 (State or country)

19 MAIDEN NAME OF MOTHER Information Unavailable

20 BIRTHPLACE OF MOTHER (City) Information Unavailable
 (State or country)

21 Informant (Address) Elgie M. Day
64 Lincoln St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
 was filed with me BEFORE the burial or transit permit was issued:

Jacqueline Davis
 (Signature of Agent of Board of Health or other)

1600 E. 4/13/63
 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

d for burial permit
 Board of Health
 its Agent.

INSTRUCTIONS
 FOR
 FILLING OUT
 THIS CERTIFICATE

OR TYPE
 OR CAUSES
 OF DEATH

not enter
 more than one
 cause for each
 (a), (b) and (c)

does not mean
 mode of dying,
 heart failure,
 etc. It means
 cause, or compli-
 cation which caused

conditions, if any,
 gave rise to
 cause (a),
 the under-
 cause last.

conditions contrib-
 to death but not
 to the terminal
 condition given

m c.

Director
 use only

INK

APR 14 1963

62-932302

T X

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar



MAY 14 1963 AM

filed for burial permit
by Board of Health
or its Agent.

INSTRUCTIONS
FOR
MEDICAL CERTIFICATE

PRINT OR TYPE
USE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

this does not mean
mode of dying,
such as heart failure,
pneumonia, etc. It means
disease, or complica-
tions which caused
it.

conditions, if any,
which gave rise to
have cause (a),
causing the under-
lying cause last.

Conditions contrib-
uting to death but not
contributing to the terminal
condition given
(a).

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

03749

STANDARD

CERTIFICATE OF DEATH

Registered No.

The Children's Hospital Med. Ctr. St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME Baby Boy Dunne

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

914A Shirley

Winthrop

(a) Residence. No.

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days. 20 hrs. 45 min.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 2, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 1, 1963, to April 2, 1963.

I last saw him live on April 2, 1963, death is said to have occurred on the date stated above, at 5:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Respiratory Distress

Due To Prematurity

(b) Due To

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Murray Bengard, M. D.

(Print or Type Name)

(Address) 300 Longwood Ave. Date 4-2-63

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Apr 4 1963

7 NAME OF FUNERAL DIRECTOR Ernest Cagiano

ADDRESS 147 Winthrop St Winthrop

Received and Filed APR 4 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE.....Years.....Months.....Days 11 under 24 hours 20 Hours 45 Minutes

13 Usual

Occupation:

(Kind of work done during most of working life)

14 Industry

or Business:

15 Social Security No. None

16 BIRTHPLACE (City) Winthrop

(State or country) Mass

17 NAME OF FATHER Robert Dunne

18 BIRTHPLACE OF FATHER (City) Boston

(State or country) Mass

19 MAIDEN NAME OF MOTHER Sharon Knox

20 BIRTHPLACE OF MOTHER (City) Winthrop

(State or country) Mass

21 Informant Robert Dunne

(Address) 914A Shirley St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jacqueline Barato
(Signature of Agent of Board of Health or other)

16029
(Official Designation)

4/3/63
(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie
City Registrar



MAY 14 1963 AM

not for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
OF DEATH

not enter
more than one
cause for each
(a), (b) and (c)

does not mean
mode of dying,
heart failure,
a, etc. It means
cause, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
ng the under-
cause last.

ditions contrib-
to death but not
to the terminal
condition given

20.1
81

x70

Director
use only

CK Ink.
Y 14 1963

62-932382

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

03820

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Alice Howland (Alice Davies Howland (Gilbert))
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 33 Bellevue Avenue
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 3 days. In place of residence, 13 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 2 1963
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from March 29 1963 to April 2 1963

I last saw her alive on April 2 1963 death is said to have occurred on the date stated above, at 10:35a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC RUPTURE

Due To ACUTE MYOCARDIAL INFARCTION

(b) 4 DAYS

Due To ARTERIOSCLEROTIC HEART DISEASE

OTHER SIGNIFICANT CONDITIONS HYPERTENSIVE HEART DISEASE

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles L. Cloy, M.D.

(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Apr. 2 1963

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 5, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Mont

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed APR 9 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of George Howland (Husband's name in full)

12 AGE 82 years 3 months 7 days If under 24 hours Hours Minutes

13 Usual Occupation housewife (Kind of work done during most working life)

14 Industry or Business own home

15 Social Security No. 015-16-9440-E

16 BIRTHPLACE (City) Chelsea (State or country) Massachusetts

17 NAME OF FATHER Samuel Barry Gilbert

18 BIRTHPLACE OF FATHER (City) England (State or country)

19 MAIDEN NAME OF MOTHER Mary Ann Fraser

20 BIRTHPLACE OF MOTHER (City) Nova Scotia (State or country)

21 Informant Mrs. Max LeRoy Rorick (Address)

33 Bellevue Ave. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jacqueline Rorick

(Signature of Agent of Board of Health or other)

16844 4/5-1963

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

T

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar



MAY 14 1963 AM

ed for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
ore than one
use for each
(a), (b) and (c)

does not mean
mode of dying,
as heart failure,
ia, etc. It means
cause, or compli-
which caused

ditions, if any,
ch gave rise to
e cause (a),
ing the under-
cause last.
C.
ditions contrib-
to death but not
to the terminal
condition given

Director

use only

CK Ink.

AY 14 1963

62-932382

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL

2 FULL NAME **John L Reynolds**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

9 Eliot Street

(a) Residence. No. (Usual place of abode)

Winthrop, Mass.

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **April 2 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
March 22 1963, to **April 2 1963**
I last saw him alive on **April 2 1963**, death is said to
have occurred on the date stated above, at **12:18pm**.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Subarachnoid Hemorrhage**Due To **Aneurysm of Anterior**(b) **Communicating Artery**

Due To

(c)

OTHER SIGNIFICANT
CONDITIONS **Hypertensive Heart
Disease**

Was autopsy performed? **YES**What test confirmed diagnosis? **AUTOPSY**

5 Was disease or injury in any way related to occupation of deceased?
If so, specify **eelepy**

(Signature) **Charles L. Clay**, M. D.**Charles L. Clay, M.D.**

(Print or Type Name)

(Address) **Ass't. Dir., Mass. Gen'l. Hosp.**, Date **Apr. 2 1963**

6 **ST PATRICKS STONHAM**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **APRIL 5 1963**7 NAME OF FUNERAL DIRECTOR **FRANCIS H. BROWN**ADDRESS **34 BOW ST SOMERVILLE**Received and filed **APR 8 1963**, A. 19.**Charles H. Mackie**

(Registrar)

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. **03781**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) **NONE**

Winthrop, Mass.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced **EDITH GRACE**
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 **52** Years **4** Months **23** Days If under 24 hours
AGES.....Hours.....Minutes

13 Usual Occupation: **MACHINIST**
(Kind of work done during most working life)

14 Industry or Business: **PORTSMOUTH NAVY YARD**

15 Social Security No. **029-05-6333**

16 BIRTHPLACE (City) **SOMERVILLE**
(State or country) **MASS**

17 NAME OF FATHER **JOHN A REYNOLDS**

18 BIRTHPLACE OF FATHER (City) **STONHAM**
(State or country) **MASS**

19 MAIDEN NAME OF MOTHER **ANNIE G CRONIN**

20 BIRTHPLACE OF MOTHER (City) **EAST ORANGE**
(State or country) **NEW JERSEY**

21 Informant **EDITH REYNOLDS (WIFE)**
(Address) **9 ELLIOT ST. WINTHROP MASS**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Raymond J. Rogers
(Signature of Agent of Board of Health or other)

16033

(Official Designation)

4/14/63
(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar



MAY 14 1963 AM

FORM R-301

led for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

INT OR TYPE
SE OR CAUSES
OF DEATH

do not enter
more than one
cause for each
(a), (b) and (c)

is does not mean
mode of dying,
as heart failure,
mia, etc. It means
disease, or compli-
cations which caused

ditions, if any,
which gave rise to
above cause (a),
causing the under-
lying cause last.

Conditions contrib-
uting to death but not
leading to the terminal
condition given
(d)

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 03813

* Veterans Administration Hospital

(If death occurred in a hospital or institution,
give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME Elta J. Nelson (Maiden name: Jones)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran. WWII
if so specify WAR)

(a) Residence. No. 46 Moore St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death years month 19 days. In place of residence 17 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 4 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Mar. 16 1963 to Apr. 4 1963

death is said to

have occurred on the date stated above, at 4:30A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Colitis

(b) Due To Fatty nutritional cirrhosis yrs.

(c) Due To Megaloblastic anemia unk

OTHER SIGNIFICANT CONDITIONS Pneumonia wks.

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) S. Miller, M. D.

(Print or Type Name)

(Address) VAH, Boston, Mass. Date Apr. 4 1963

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 6 1963

7 NAME OF FUNERAL DIRECTOR Kirby Funeral Home

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed APR 9 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Bruce Nelson
(Husband's name in full)

12 AGE 53 Years 3 Months 25 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 525 28 4310

16 BIRTHPLACE (City) Agular
(State or country) Colorado

17 NAME OF FATHER Homer H. Jones

18 BIRTHPLACE OF FATHER (City) Rich Hill
(State or country) Miss.

19 MAIDEN NAME OF MOTHER Elta Howe

20 BIRTHPLACE OF MOTHER (City) Macon
(State or country) Miss.

21 Informant V. A. Hospital Records, 150 S.

(Address) Huntington Ave., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Raymond Pigeon
(Signature of Agent of Board of Health or other)

#B16057 4/5/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

14 1963

81
5 07
1

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED



MAY 14 1963 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

1

PLACE OF DEATH

Essex

(County)

Gloucester

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

Gloucester

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

No. Hillcrest Nursing Home

{ (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Ella Margaret Graff (Kennedy)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a
U. S. War Veteran,
if so specify WAR, No

(a) Residence, No. 31 Villa Avenue

(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 7.....days. In place of residence 45.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 6, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Aug. 15 1962 to April 6, 1963
I last saw er alive on April 1, 1963, death is said to
have occurred on the date stated above, at 8:30P m.INTERVAL
BETWEEN
ONSET AND
DEATH
over

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerosis general

5 yrs.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? Physcial Exam5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) W.M. Poland

M. D.

(Address) Gloucester, Mass. 4/6 63

6 Woodlawn Crem. Everett, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 9, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed MAY 10 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widowed

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Harry Graff
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years 6 Months 28 Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. none
New York16 BIRTHPLACE (City) N.Y.
(State or country)

17 NAME OF FATHER Edward G. Kennedy

18 BIRTHPLACE OF FATHER (City) St. John
(State or country) N.B.

19 MAIDEN NAME OF MOTHER Margaret Jane Greene

20 BIRTHPLACE OF MOTHER (City) New York
(State or country) N.Y.21 Informant Mrs. James Stavros
(Address) B.N. Road Gloucester, Mass

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED April 8, 1963

X

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSCOPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Danvers

(City or town making return)

Registered No. 22

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

 2 FULL NAME Margaret MacCarthy (Shea) (Was deceased a U. S. War Veteran, if so specify WAR) No
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

 (a) Residence. No. 66 Summitt Avenue Winthrop, Mass.
 (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....1 months.....19 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH April 15, 1963
 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerosis, fracture left hip, before adm. to hospital

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury Feb. 15, 1963

If accidental, was injury causally related to the death? no

 Where did injury occur? Winthrop
 (City or town and State)

 Did injury occur in or about home, on farm, in industrial place, or in public place? Com. Hospital
 (Specify type of place)

 Manner of injury Fall to floor
 (How did injury occur?)

Nature of injury Fract. left hip

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify Ralph E. Foss

(Signed) Ralph E. Foss M. D.

(Address) Peabody, Mass. Date 4/15 1963

 7 Winthrop Cemetery, Winthrop
 Place of Burial or Cremation. (City or Town)

DATE OF BURIAL April 18, 1963

 8 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
 ADDRESS Winthrop, Mass.

Received and filed MAY 10 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

 9 SEX female 10 COLOR white 11 CITIZEN OF U.S. YES ☐ NO ☐ 12 SINGLE ☐ MARRIED ☒ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐

12a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

 (or) WIFE of John T. MacCarthy
 (Husband's name in full)

13 DATE OF BIRTH

14 AGE 87 Years 0 Months 6 Days If under 24 hoursHoursMinutes

 15 Usual Occupation: Unable to work
 (Kind of work done during most of working life)

16 Industry or Business:

17 Social Security No. 024-09-9797

 18 BIRTHPLACE (City) Unknown
 (State or country) So. Wales, England

 19 NAME OF FATHER Patrick Shea
 20 BIRTHPLACE OF FATHER (City) Unknown
 (State or country) England
 21 MAIDEN NAME OF MOTHER Margaret Dacey
 22 BIRTHPLACE OF MOTHER (City) Unknown
 (State or country) England

 23 Informant Mary E. Sheehan
 (Address) Hathorne, Mass.

A TRUE COPY.

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED April 17, 1963

T X

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

SUFFOLK

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

St. }

(If death occurred in a hospital or institution,
give its NAME instead of street and number)2 NAME OF FETUS Baby Girl Otter
(if given)3 DATE OF DELIVERY May 2 1963
(Month) (Day) (Year)4 SEX Male.....Female ☒ Undetermined.....

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single ☒ Twin..... Triplet7 IF MULTIPLE BIRTH, BORN:
1st.....2nd.....3rd.....

FATHER

8 FULL NAME Raymond, Otter

9 RESIDENCE, NO. 142 Pauline St. STREET
CITY OR TOWN Winthrop STATE Mass

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 27 (Years)

12 PLACE OF BIRTH McGregor, Texas
(City or Town) (State or country)

13 OCCUPATION Mechanic

MOTHER

14 MAIDEN NAME Cynthia Herbert
PRESENT NAME Cynthia Otter15 RESIDENCE, NO. 142 Pauline St. STREET
CITY OR TOWN Winthrop STATE Mass

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 21 (Years)

18 PLACE OF BIRTH Winthrop, Mass.
(City or Town) (State or country)

19 INFORMANT Raymond Otter

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus) 1

(a) How many children are now living? 1

(b) How many children were born alive but are now dead? None

(c) How many previous fetal deaths of ANY gestation age? None

21 LENGTH OF PREGNANCY completed weeks 28

22 Weight Lb. 2 Oz. 13
(or Grams)23 WHEN DID FETUS DIE?
☒ Before Labor
During Labor Unknown24 AUTOPSY
Yes No ☒25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Premature rupture of membranes

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 3, 196327 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.
ADDRESS 917 Bennington St. E. Boston

Received and filed

MAY 3 - 1963

19

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

Registered No. 93

In giving
CAUSE OF
FETAL DEATHDo not enter
more than one
cause for each
of (a), (b)
and (c)I or maternal
condition causing
fetal death (do
not use such
causes as stillbirth
or prematurity.)I and/or mal-
formation of
fetus, which gave
rise to above
cause (a), stating
underlying
cause last.I or maternal
condition causing
fetal death (do
not use such
causes as stillbirth
or prematurity.)I HEREBY CERTIFY that this delivery occurred on the date stated
above at 10:16 p.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

M. Traubstein, M.D.

(PRINT OR TYPE NAME)

Address 73 Bartlett Rd., Date May 2 1963
Winthrop, Mass.I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:Joseph E. Serianow
(Signature of Agent of Board of Health or other)Health Officer
(Official Designation)May 3, 1963
(Date of Issue of Permit)

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
cations, if any,
gave rise to
cause (a),
the terminal
condition given

ditions contrib-
to death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 35 Enfield Road



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 23

2 FULL NAME Ellen M. Skehan
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 35 Enfield Road
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 35 years.....months.....days. In place of residence 35 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 2, 1963.
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at 6:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due to natural causes, probably

(b) a cerebrovascular

Due To occlusion on basis of history

(c) of arteriosclerosis and hypertension

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health

Was autopsy performed? Charles Liberman, M.D.

What test confirmed diagnosis? h

5 Was disease or injury in any way related to occupation of deceased? h

If so, specify Charles Liberman, M. D.

(Signature) CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 5/3/1963

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 6, 19 63

7 NAME OF FUNERAL DIRECTOR Arthur J O'Maley

ADDRESS Winthrop Mass
MAY 3-1963

Received and filed.....19.....

INTERVAL
BETWEEN
ONSET AND
DEATH

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Thomas E. Skehan
(Give maiden name of wife in full)

(or) WIFE of Thomas E. Skehan
(Husband's name in full)

12 87
AGE 87 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No.....

16 BIRTHPLACE (City) East Boston Mass
(State or country)

17 NAME OF FATHER Dennis Harrington

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary McCarthy

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Robert W. Skehan
(Address) 35 Enfield Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seriani
(Signature of Agent of Board of Health or other)

Health Officer May 3, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

(Registrar)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

MAY 3 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause lost.

ditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

**STANDARD
CERTIFICATE OF DEATH**

Registered No.

1 **PLACE OF DEATH**
Suffolk
(County)
Winthrop
(City or Town)
No. Mayflower Nursing Home
(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 **FULL NAME** Giuseppe Recca
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 136 Trenton Street,
(Usual place of abode) East Boston, Mass. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH			PERSONAL AND STATISTICAL PARTICULARS		
3 DATE OF DEATH May 3 1963 (Month) (Day) (Year)	8 SEX male	9 COLOR white	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN widowed		
4 I HEREBY CERTIFY That I attended deceased from May 20, 1962 to May 3, 1963 I last saw him alive on May 2, 1963, death is said to have occurred on the date stated above, at 6:00 A.M.			11 If married, widowed, or divorced HUSBAND of Maria Panarino (Give maiden name of wife in full)		
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia			(or) WIFE of..... (Husband's name in full)		
Due To (b)			12 AGE 79 Years.....Months.....Days If under 24 hoursHours.....Minutes		
Due To (c)			13 Usual Occupation: Retired (Kind of work done during most working life)		
OTHER SIGNIFICANT CONDITIONS Cerebral Hemorrhage			14 Industry or Business: ****		
Was autopsy performed? No			15 Social Security No. 031-10-4755		
What test confirmed diagnosis? Clinical			16 BIRTHPLACE (City) (State or country) Italy		
5 Was disease or injury in any way related to occupation of deceased?			17 NAME OF FATHER Rosario Recca		
If so, specify			18 BIRTHPLACE OF FATHER (City) (State or country) Italy		
(Signature) Charles A. Ferrero, M. D. (Print or Type Name)			19 MAIDEN NAME OF MOTHER Rosa Lentini		
(Address) 172 Belmont St., Winthrop Date 5/13/63			20 BIRTHPLACE OF MOTHER (City) (State or country) Italy		
6 Woodlawn Cemetery Everett Place of Burial or Cremation (City or Town)			21 Informant (Address) Angelo Recca (son) 136 Trenton St., East Boston, Mass.		
DATE OF BURIAL May 6, 1963			I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Ralph E. Sciarano (Signature of Agent of Board of Health or other) Health Officer May 6, 1963 (Official Designation) (Date of Issue of Permit)		
7 NAME OF FUNERAL DIRECTOR Vincent Rapino					
ADDRESS 9 Chelsea St., East Boston, Mass.					
Received and filed MAY 6 - 1963					

(Registrar)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

not enter
more than one
cause for each
(b) and (c)

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
more than one
cause for each
(b) and (c)

does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
which caused

conditions, if any,
gave rise to
cause (a),
the under-
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conditions contrib-
to death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No.

40 Shirley Street

2 FULL NAME

Louis Russell Cobb

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

40 Shirley Street

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 30 years 11 months 11 days. In place of residence 61 years 6 months 11 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 11 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6-17-61, to 5-11-63.

I last saw him live on May 10, 1963, death is said to have occurred on the date stated above, at 6:25a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) acute myocardial infarction 1/2 hr

Due To arteriosclerotic heart disease 3yrs

(b) Due To generalized arteriosclerosis 5yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical & lab

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) M. Traunstein, Jr., M.D.

M. Traunstein, Jr., M.D.

(Print or Type Name)

(Address) 73 Bartlett Rd. Date 5-11-63
Winthrop, Mass.6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 14, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Wintrop St. Winthrop, Mass.

Received and filed MAY 13 1963

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Myrtle May Ackerman
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 61 Years 5 Months 11 Days If under 24 hours
Hours Minutes13 Usual Occupation: Foreman
(Kind of work done during most working life)

14 Industry or Business Winthrop Water Department

15 Social Security No. 010-09-8907

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

17 NAME OF FATHER Robert Cobb

18 BIRTHPLACE OF FATHER (City) Prince Edward Island
(State or country) Canada

19 MAIDEN NAME OF MOTHER Alma Collette Floyd

20 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Massachusetts21 Informant Mrs. Louis R. Cobb
(Address) 40 Shirley St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:(Signature of Agent of Board of Health or other)
Health Officer May 13-63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
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PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. 49 Waldemar Avenue



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 37

(If death occurred in a hospital or institution,
St.) give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Florence May Gingrich(Benson)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 49 Waldemar Avenue Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death. 50 years.....months.....days. In place of residence. 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 15 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at 2:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death due to natural causes

Due To (b) presumably coronary occlusion

Due To (c) on basis of history.
Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) Winthrop, Mass Date 5/16/1963

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 18, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

MAY 17 1963

Received and filed 19.....

INTERVAL
BETWEEN
ONSET AND
DEATH

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of John Edward Gingrich
(Husband's name in full)

12 AGE 70 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Office manager
Occupation (Kind of work done during most working life)

14 Industry or Business: Boston Y.W.C.A.

15 Social Security No. 025-26-0168

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Edgar Nicol Benson

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Mary Flora Gorman

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Massachusetts

21 Informant Harry N. Benson
(Address) 290 Elm St. Walpole, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
has been with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer May 17 1963
(Official Designation) (Date of Issue of Permit)

(Registrar)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE
MAY 1 1955 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No.

No. 109 Pleasant St., Winthrop

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOHN FRANCIS GALLAGHER

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 109 Pleasant Street

(Usual place of abode)

St. Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death 29 years.....months.....days. In place of residence 29 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 17 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h.....alive on , 19....., death is said to
have occurred on the date stated above, at 9:05 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to
natural causes, probably

(b) acute coronary occlusion

(c) on basis of history.

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health
Charles Liberman M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 5/17/1963

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 21, 1963

7 NAME OF FUNERAL DIRECTOR FRANK H. CARR

ADDRESS 79 Elm St., Charlestown

Received and filed MAY 20 1963

..... 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED SINGLE
DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 74 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Photo-Engraver (ret.)
(Kind of work done during most working life)

14 Industry or Business: Donovan & Sullivan Co.

15 Social Security No.

16 BIRTHPLACE (City) Donegal
(State or country) Ireland

17 NAME OF FATHER Daniel Gallagher

18 BIRTHPLACE OF FATHER (City) Donegal
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Bradley

20 BIRTHPLACE OF MOTHER (City) Derry
(State or country) Ireland

21 Informant Miss E. Veronica Gallagher
(Address) 109 Pleasant St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Liberman (M.D.)
(Signature of Agent of Board of Health or other)

Health Officer May 20 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

RECEIVED
MAY 20 1963 AM
SPACED FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

or burial permit
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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 283 Court Road

2 FULL NAME Warren M. Campbell

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 283 Court Road
(Usual place of abode)

Length of stay: In place of death 19 years months days. In place of residence 21 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 21 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
MAY 11, 1963, to MAY 21, 1963.
I last saw him live on MAY 20, 1963, death is said to
have occurred on the date stated above, at 3:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY THROMBOSIS

Due To (b) ARTERIO SCLEROSIS 2 YRS

Due To (c)

OTHER SIGNIFICANT CONDITIONS PREVIOUS ATTACK 4 YRS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? YES
If so, specify

(Signature) A. N. Caplan, M. D.

(Address) 18 SPRINGTON ST EAST BOSTON MAY 21 1963

6 WINTHROP CEMETERY WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 24 1963

7 NAME OF FUNERAL DIRECTOR ARTHUR PORCELLA

ADDRESS BEACHMONT, MASS.

Received and filed MAY 23 1963

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran,
if so specify WAR) No

Winthrop
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced
HUSBAND of Emma K. Kinsella
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 2-7-1911
AGE 52 Years 3 Months 14 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Retired- Civil Engineer
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Revere
(State or country) Mass.

17 NAME OF FATHER William W. K. Campbell

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Elizabeth J. Crowley

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Mrs. Emma K. Campbell
(Address) 283 Court Rd., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Simon
(Signature of Agent of Board of Health or other) (Official Designation)
May 23 1963
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
and of Health
Agent.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No.

No. 39 Grovers Ave.

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Daniel J. Geary
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, no
if so specify WAR)

(a) Residence. No. 66 Winthrop Shore Drive
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 2 years.....months.....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 21, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19.60 to 19.63
I last saw him live on May 18, 19.63 death is said to
have occurred on the date stated above, at 8:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

Due To (b) Atherosclerosis - generalized

Due To (c)

OTHER SIGNIFICANT CONDITIONS Spondylitis

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph E. Geary, M. D.

(Print or Type Name) Joseph E. Geary

(Address) 194 W. Cambridge St. Date 5/22/63

6 New Calvary Boston, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 24, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass.

Received and filed MAY 23 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) Married
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Mary F. Geary (Reardon)
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AG 85 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Accountant
(Kind of work done during most working life)

14 Industry or Business: N.E. News Co

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass

17 NAME OF FATHER John Geary

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Mary Burns

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant Mary F. Geary
(Address) 66 Winthrop Shore Drive

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Geary (Signature of Agent of Board of Health or other)

Health Officer 22 May 23, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
L CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
, (b) and (c)

does not mean
ode of dying,
heart failure,
etc. It means
ase, or compli-
which caused

itions, if any,
gave rise to
cause (a),
g the under-
cause last.

ditions contrib-
o death but not
to the terminal
condition, given
-11

P.12

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 100

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Town Hall Winthrop

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Amelia M. Thibeau

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a no
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 144 Main Street
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 25 years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 21, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Nov 52 to May 14, 1963
I last saw her alive on May 14, 1963, death is said to
have occurred on the date stated above, at 3:40 P.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarctionDue To coronary arteriosclerosis
(b)Due To
(c)OTHER SIGNIFICANT CONDITIONS Myocardial infarction
1958; Angina pectoris

Was autopsy performed?

What test confirmed diagnosis? Ecg5 Was disease or injury in any way related to occupation of deceased?
If so, specify No(Signature) H. B. Greenfield, M. D.H. B. Greenfield
447 Shirley St (Print or Type Name) Winthrop, Mass.
(Address) Date 5-21, 19636 Winthrop Winthrop
Place of Burial or Cremation (City or Town)DATE OF BURIAL May 24, 19637 NAME OF FUNERAL DIRECTOR Arthur J. O'MaleyADDRESS Winthrop Mass.Received and filed MAY 23 1963, 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Clifford Thibeau

(Husband's name in full)

12 AGE 56 Years 10 Months 28 Days If under 24 hours
Hours.....Minutes13 Usual Occupation: Senior Clerk
(Kind of work done during most working life)14 Industry or Business: Winthrop Water Dep't15 Social Security No. 031-09-923616 BIRTHPLACE (City) Lowell, Mass
(State or country)17 NAME OF FATHER John Stempien Stympin18 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country) Austria19 MAIDEN NAME OF MOTHER Annie Youlaka
Cannot be learned20 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country) Austria21 Informant Robert Thibeau
(Address) 144 Main St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Brennan
(Signature of Agent of Board of Health or other)
May 23 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
case, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME

Mary Hale

(If deceased is a married, widowed or divorced woman, give also maiden name.)

67 Wordsworth Street

(a) Residence. No.

(Usual place of abode)

St. East Boston, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 31 - 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
1963, to MAY 31, 1963I last saw her alive on MAY 31, 1963, death is said to
have occurred on the date stated above, at 7:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebro-vascular accident

Due To General arteriosclerosis

Due To
(c)OTHER SIGNIFICANT CONDITIONS Left leg amputate due to
arterial thrombosis 1961

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?

If so, specify No

(Signature) Charles Meloni M.D.

CHARLES MELONI

(Print or Type Name)

(Address) 305 Havre St E Boston Date MAY 31 1963

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 3 1963

7 NAME OF FUNERAL DIRECTOR Frederick J. MacRath

ADDRESS East Boston

Received and filed JUN 5 1963

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 1003

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Female White MARRIED
WIDOWED
DIVORCED
UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE 74 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: Housework
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. 028-05-9768

16 BIRTHPLACE (City) CANADA
(State or country)

17 NAME OF FATHER Joseph Hale

18 BIRTHPLACE OF FATHER (City) CANADA
(State or country)

19 MAIDEN NAME OF MOTHER MARY Sherman

20 BIRTHPLACE OF MOTHER (City) CANADA
(State or country)21 Informant Rita Heil
(Address) 67 Wordsworth St. E BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

RECEIVED The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUN 5 1963

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

NT OR TYPE
E OR CAUSES
F DEATH

o not enter
more than one
use for each
(a), (b) and (c)

does not mean
mode of dying,
as heart failure,
a, etc. It means
cause, or compli-
which caused

ditions, if any,
h gave rise to
e cause (a),
ng the under-
cause last.

conditions contrib-
to death but not
to the terminal
condition given

153.8
47
X71

8-1983

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 111121

PLACE OF DEATH 1 Suffolk (County)
East Boston (City or Town)
Princeton Shelby Nursing Home No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Eva (Golden) Kalish (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 37 Mermaid Ave. St. Winthrop (If nonresident, give city or town and State)

Length of stay: In place of death, 4 years, 4 months, days. In place of residence, 20 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 22 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 19 50, to April 22 1963
I last saw her alive on April 22, 1963, death is said to have occurred on the date stated above, at 5:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Colon 6 yrs.
(b) with generalized
(c) carcinomatosis, especially to liver

OTHER SIGNIFICANT CONDITIONS None.

Was autopsy performed? No
What test confirmed diagnosis? Operative - Pathological.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 4/23/1963

6 T. Gend. Israel of Winthrop, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 23 1963

7 NAME OF FUNERAL DIRECTOR Arnold Goler

ADDRESS 1668 Beacon ST, Brookline

Received and filed APR 24 1963

Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN widowed

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Joseph Kalish (Husband's name in full)

12 AGE 68 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Russia (State or country)

17 NAME OF FATHER Levi Golden

18 BIRTHPLACE OF FATHER (City) Russia (State or country)

19 MAIDEN NAME OF MOTHER CWBL

20 BIRTHPLACE OF MOTHER (City) Russia (State or country)

21 Informant Myer Press, 35 Mermaid Ave. Winthrop (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Raymond J. Rogers
(Signature of Agent of Board of Health or other)
16338 4/23/63
(Official Designation) (Date of Issue of Permit)

THIS COPY ATTEST:

Charles H. Mackie

City Registrar

JUL 8 1963 AM



RECEIVED

d for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
VITAL CERTIFICATE

T OR TYPE
OR CAUSES
DEATH

not enter
more than one
cause for each
(b) and (c)

does not mean
mode of dying,
heart failure,
etc. It means
cause, or compli-
cation which caused

ditions, if any,
which gave rise to
cause (a),
the under-
cause last.

ditions contrib-
to death but not
to the terminal
condition given

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31
31
31

9-1963

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 04828

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. BARNEY HILL MED. CENTRE

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPH BRENDEN SHEA

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence No. 35 SIREN ST

(Usual place of abode)

St. WINTHROP

(If nonresident, give city or town and State)

Length of stay: In place of death... years 2 months... days. In place of residence 33 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 4 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from Jan. 1963 to May 4 1963

I last saw him live on May 5 1963, death is said to have occurred on the date stated above, at 5 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRO VASCULAR ACCIDENT

INTERVAL BETWEEN ONSET AND DEATH

3 mos

(b) Due To ARTERIO SCLEROSIS

(c) Due To

OTHER SIGNIFICANT CONDITIONS DIABETUS MELLITUS 100 DUODENAL ULCER 100

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify No

(Signature) John Adams Jr, M. D.

(Print or Type Name) JOHN ADAMS JR

(Address) 704 HUNTINGTON AVE. 5/4 1963 BOSTON

6 NEW CHURCH BOSTON

DATE OF BURIAL MAY 7 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W. HIRBY

ADDRESS WINTHROP

Received and filed MAY 8 1963

Charles P. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED

11 If married, widowed, or divorced HUSBAND of CATHERINE HORLEY (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 76 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation MANAGER (Kind of work done during most working life)

14 Industry or Business FIRST NAT STORES

15 Social Security No. 038-05-3878

16 BIRTHPLACE (City) IRELAND (State or country)

17 NAME OF FATHER MICHAEL SHEA

18 BIRTHPLACE OF FATHER (City) IRELAND (State or country)

19 MAIDEN NAME OF MOTHER MARY FLAYHIVE

20 BIRTHPLACE OF MOTHER (City) IRELAND (State or country)

21 Informant MISS MARY K. SHEA (Address) 35 SIREN ST WINTHROP MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie
City Registrar



JUL - 9 1963 AM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

Director

use only

K Ink.

9-1963

2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

0-1866

Registered No.

STANDARD
CERTIFICATE OF DEATH

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

2 FULL NAME Loretta Thompson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 112 Pleasant St.
(Usual place of abode)

St. Winthrop Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 5, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
April 24, 1963, to May 5, 1963
I last saw him alive on May 5, 1963 death is said to

have occurred on the date stated above, at 6 am. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MyxedemaINTERVAL
BETWEEN
ONSET AND
DEATH5 Yrs

Due To (b) Idiopathic atrophy of
Thyroid

5 Yrs

Due To
(c)

OTHER SIGNIFICANT
CONDITIONS Diabetes Mellitus

unk
Yrs

Was autopsy performed? yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify no

(Signature) Charles L. Clay, M.D., M. D.Charles L. Clay, M.D.

(Print or Type Name)

(Address) Ann's. Dir., Mass. Gen'l. Hosp. Date May 5, 1963

Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 7 19637 NAME OF FUNERAL DIRECTOR FREDERICK J. MACRATHADDRESS EAST BostonReceived and filed MAY 8 1963Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed

11 If married, widowed, or divorced

HUSBAND of

(or) WIFE of Henry J. Thompson
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 75 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housework
(Kind of work done during most working life)

14 Industry or Business: OWN Home15 Social Security No. CNBL16 BIRTHPLACE (City) SQUANTON MASS.
(State or country)17 NAME OF FATHER Joshua C. Small

18 BIRTHPLACE OF FATHER (City) MAINE
(State or country)

19 MAIDEN NAME OF MOTHER CLARA TRACY

20 BIRTHPLACE OF MOTHER (City) New Brunswick
(State or country)

21 Informant Avis Clark
(Address) 10 HAVER ST. East Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

WESLEY
(Official Designation)

5-6-63
(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Maclellan

City Recorder



JUL -9 1963 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SOM-10-61-931673

Medical Examiner Waivered The Commonwealth of Massachusetts

PLACE OF DEATH

Suffolk

(County)

Revere

(City or Town)

Grover Manor Hospital

No.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Revere

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 103

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

Agnes Hodgkins (Finlayson)

(Was deceased a
U. S. War Veteran,
if so specify WAR.)

(a) Residence. No.

(Usual place of abode)

115 a Summit Ave.

St.

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. 1 days. In place of residence. 40 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 15, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 14, 1963, to May 15, 1963.
I last saw him alive on May 15, 1963, death is said to have occurred on the date stated above, at 10:45A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia

(b) Due To Cerebral thrombosis

(c) Due To Hypertensive heart disease

OTHER SIGNIFICANT CONDITIONS

Left hemiplegia

Was autopsy performed?

No

What test confirmed diagnosis? Clinical signs

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) James F. Burns

(Address) 537 Broadway Everett Date 5/15 63

Winthrop Cemetery Winthrop

6 Place of Burial or Cremation

May 18, 63

DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed

JUN 14 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED Widowed
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Ralph Hodgkins (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 86 1 14 Years Months Days

If under 24 hours Hours Minutes

13 Usual Occupation: Housewife

(Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No.

16 BIRTHPLACE (City) New Brunswick, Canada
(State or country)

17 NAME OF FATHER

Murdock Finlayson

18 BIRTHPLACE OF FATHER (City)

(State or country) New Brunswick, Canada

19 MAIDEN NAME OF MOTHER

Adeline Petley

20 BIRTHPLACE OF MOTHER (City)

(State or country) New Brunswick, Canada

21 Informant (Address)

Robert Hodgkins

40 Taylor St., Winthrop

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

May 20, 63

T V

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

JUN 14 1963 AM

THIS IS A PERMANENT RECORD
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSLexington
(City or Town making this return)COPY OF
CERTIFICATE OF DEATH

Registered No. 102

PLACE OF DEATH

Middlesex
(County)Lexington
(City or Town)

No. Metropolitan State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ANNA L. CANAVAN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR, No(a) Residence, No. 43 Hutchinson
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death 5 years, 6 months, 15 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 22 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
May 22, 1963, to May 22, 1963
I last saw her alive on May 22, 1963 death is said to
have occurred on the date stated above, at 3:45a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

(b) Due To Arteriosclerotic Heart
Disease

(c) Due To Generalized Arteriosclerosis

OTHER
SIGNIFICANT
CONDITIONSINTERVAL
BETWEEN
ONSET AND
DEATH

?

?

?

Was autopsy performed? no
What test confirmed diagnosis? clinical5 Was disease or injury in any way related to occupation of deceased? no
If so, specify(Signed) W. M. Hanna
W. M. Hanna, M. D.

(Address) Met. State Hospital May 22, 63

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 25 1963

7 NAME OF FUNERAL DIRECTOR O'Malley Funeral Home

ADDRESS Winthrop, Massachusetts

Received and filed JUL 1 - 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Single
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 74 Years 7 Months 2 Days If under 24 hours
Hours Minutes13 Usual Occupation Bookkeeper
(Kind of work done during most working life)14 Industry
or Business:

15 Social Security No. Cannot learn

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Patrick J. Canavan

18 BIRTHPLACE OF FATHER (City) Cannot learn
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Emma L. Dubberley

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country) Canada21 Informant Records, Metropolitan State
Hospital Waltham 54, Massachusetts

A TRUE COPY

ATTEST: James J. Carroll
(Registrar of City or Town where death occurred)

DATE FILED May 27 1963

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED



JUL 1 1963 AM

58
R-301

CTIONS
IFICATE
ing
DEATH

if any,
rise to
(a),
under-
last.

contrib-
but not
terminal
given

Chapter 137,
54 requires
to print or
cause or
death on
ificates, and
8. Acts of
Physi-
print or type
signature.

12 1963

213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

102

PLACE OF DEATH

Worcester
(County)
Worcester
(City or Town)



STANDARD
CERTIFICATE OF DEATH

Registered No. 1315

No. St. Mary's Hall, (Providence House) St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME (Miss Katherine L. Devereux
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. Park Avenue, St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years months days In place of residence 30 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 27 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 3/18/63, to 5/27/63
I last saw her alive on 5/26/63, death is said to have occurred on the date stated above, at 5/26/63

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) CORONARY HEART

INTERVAL
BETWEEN
ONSET AND
DEATH

Due To (b) Disease
Due To (c)

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? NO
What test confirmed diagnosis? EKG

5 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) MICHAEL B. FOX M. D.
Dr. Michael B. Fox
(Address) 390 MAIN ST Date 5/27/63

6 Holyhood Cemetery, Brookline, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 29, 1963

7 NAME OF FUNERAL DIRECTOR Arthur R. Nordgren
ADDRESS 300 Lincoln Street,

Received and filed MAY 28 1963
Robert J. O'Keefe
A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 CITIZEN OF U.S. YES X NO 11 SINGLE MARRIED WIDOWED UNKNOWN

11a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 DATE OF BIRTH May 29, 1889

13 AGE 73 Years 11 Months 28 Days If under 24 hours Hours Minutes

14 Usual Occupation: Retired (about 10 yrs) (Kind of work done during most of working life)

15 Industry or Business: Winthrop School Dept.

16 Social Security No.

17 BIRTHPLACE (City) Boston (State or country) Massachusetts

18 NAME OF FATHER Joseph J. Devereux

19 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

20 MAIDEN NAME OF MOTHER Margaret A. Dolan

21 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

22 Informant Mrs. John E. Foote, mister (Address) Old Colony Rd., Shrewsbury

I HEREBY CERTIFY that a satisfactory record was made with me (If not produced or transit permit was issued:
(Signature of Agent of Board of Health or other)
COMMISSIONER OF PUBLIC HEALTH
(Official Designation) (Date of Issue of Permit) 5/28/63



JUN 12 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 100

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Mayflower Nursing Home

{(If death occurred in a hospital or institution, give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME Rocco Vaccaro
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 94 Everett Street
(Usual place of abode)

St. East Boston
(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. 20 days. In place of residence. years. months. 25 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 2, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from April 1963, to JUNE 2, 1963
I last saw him alive on MAY 28, 1963, death is said to have occurred on the date stated above, at 930 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH 24 hrs.

Due To PRIMARY CARCINOMA

(b) RIGHT LUNG

6 mos

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? X-Ray - Bronchoscopy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Francis P. Schiappa, M. D.

(Print or Type Name)

104 Bennington St., E. B. Date 6/4 1963

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 5, 1963

7 NAME OF FUNERAL DIRECTOR Anthony P. Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed JUN 5 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN married

11 If married, widowed, or divorced HUSBAND of Victoria Malvarosa
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 77 Years. Months. Days If under 24 hours Hours. Minutes

13 Usual Occupation: Retired
(Kind of work done during most working life)

14 Industry or Business: *****

15 Social Security No. none

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Michael Vaccaro

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Pasqualina Barbera

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Victoria Vaccaro (wife)

(Address) 94 Everett St., East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seranno (Signature of Agent of Board of Health or other)

Herak Officer June 5 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

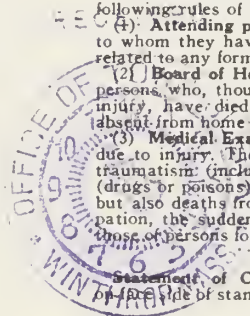
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on the side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make one entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 110

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) IL2 FULL NAME Robert Giller
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 48 Bellevue Ave St. (City or town and State)

Length of stay: In place of death. 6 years. months. days. In place of residence. 15 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 8 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
DEC 4 1959 to JUNE 5 1963
I last saw him alive on JUNE 2 1963 death is said to
have occurred on the date stated above, at 7:30 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTION 1 HR.
Due To (b) ARTERIO-SCLEROTIC HEART DISEASE 5 YRS.
Due To (c) GENERAL ARTERIO-SCLEROSIS 5 YRS.

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 6 YRS.

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)(Address) 22 Pleasant St. Date 6/8 1963
WINTHROP6 SHARON MEM PR SHARON
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 9 1963

7 NAME OF FUNERAL DIRECTOR TORG Funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed JUN 11 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced HUSBAND of LEONORE SEGAL
(Give maiden name of wife in full)
(or) WIFE of JENNIE
(Husband's name in full)12 AGE 55 Years 0 Months 28 Days If under 24 hours
Hours Minutes13 Usual Occupation SALESMAN
(Kind of work done during most of working life)

14 Industry or Business AUTOMOTIVE

15 Social Security No. 024-05-7097

16 BIRTHPLACE (City) Boston MASS
(State or country)

17 NAME OF FATHER BARNETT GILLER

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER LENA (CBE) GARDER

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant MRS JENNIE GILLER

(Address) 48 BELLEVUE Ave WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Joseph E. Scramm (S)
(Signature of Agent of Board of Health or other)Health Officer June 10 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

Sept 1 1943

DATE OF DISCHARGE

July 4 1944

RANK, RATING

Pvt

ORGANIZATION AND OUTFIT

Med. Section Hqtrs. 620 Service Unit

SERVICE NUMBER

3141 9943

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

REC-VE



JUN 11 1963 AM

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. 111

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)



No. Winthrop Convalescent Home

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number))

2 FULL NAME CARMEN SANTUCCI

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)

(a) Residence. No. 90 Richmond St
(Usual place of abode)

St. Boston Mass
(If nonresident, give city or town and State)

Length of stay: In place of death 1 years 0 months 0 days. In place of residence 1 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 12 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
FEB. 15, 1959, to JUNE 12, 1963
I last saw him alive on JUNE 11, 1963, death is said to

have occurred on the date stated above, at 7:30 P m.

INTERVAL
BETWEEN
ONSET AND
DEATH

2 DAYS

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

Due To GENERALIZED ARTERIOSCLEROSIS
(b)

15 YRS

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Palermo, M. D.

(Address) REVERE Date JUNE 12 1963

6 FAIRVIEW Boston Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 18 1963

7 NAME OF FUNERAL DIRECTOR Ernest PCAGGIANO
ADDRESS 147 Winthrop St Winthrop

Received and filed JUN 14 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Widowed
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Unknown

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 88 Years 6 Months 23 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Information unavailable
(Kind of work done during most of working life)

14 Industry
or Business:

15 Social Security No. 113-07-1638

16 BIRTHPLACE (City)
(State or country) Italy

17 NAME OF FATHER Information unavailable

18 BIRTHPLACE OF FATHER (City)
(State or country) Italy

19 MAIDEN NAME OF MOTHER Information unavailable

20 BIRTHPLACE OF MOTHER (City)
(State or country) Italy

21 Informant unavailable
(Address) Nursing Home Records

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seranno
(Signature of Agent of Board of Health or other)

Health Officer June 14, 1963
(Official Designation) (Date of Issue of Permit)

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . . General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made? . . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 112

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 453 Shirley St.,

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME John W. Flanagan

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 453 Shirley St.,
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 22 years.....months.....days. In place of residence 74 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 13, 1963.
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19......

I last saw h.....alive on....., 19....., death is said to have occurred on the date stated above, at 1:05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

~~Death~~ presumably due to natural causes, probably acute coronary occlusion on basis of history and treatment.

INTERVAL BETWEEN ONSET AND DEATH

Due To causes, probably acute coronary occlusion on basis of history and treatment.

(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS

Winthrop Board of Health
Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS Date 6/13/1962

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 15 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUN 14 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

11 If married, widowed, or divorced HUSBAND of Margaret M. Mooney
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 74 AGE 74 Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation Retired Fireman
(Kind of work done during most working life)

14 Industry or Business Fire Dep't

15 Social Security No.

16 BIRTHPLACE (City) Winthrop Mass
(State or country)

17 NAME OF FATHER William N. Flanagan

18 BIRTHPLACE OF FATHER (City) East Boston Mass
(State or country)

19 MAIDEN NAME OF MOTHER Margaret McQuarrie

20 BIRTHPLACE OF MOTHER Cannot be learned
(State or country)

21 Informant Arthur J. O'Maley
(Address)

79 Atlantic St., Winthrop Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Liberman (Signature of Agent of Board of Health or other)

Health Officer June 14 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

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82

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 113

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Andrew J. Reagan
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 33 Hutchinson St.
(Usual place of abode) St. (If nonresident, give city or town and State)

Length of stay: In place of death. 9 years. 9 months. 9 days. In place of residence 30 years. 30 months. 30 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 16, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 29, 1963, to June 16, 1963.
I last saw him on June 16, 1963, death is said to have occurred on the date stated above, at 1:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Artery Occlusion

(b) Due To Coronary Arteriosclerotic Heart Disease

(c) Due To Hypertension

OTHER SIGNIFICANT CONDITIONS Adenocarcinoma of Urinary Bladder

Was autopsy performed? Yes

What test confirmed diagnosis Clinical, Post mortem

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signature) Charles Liberman M. D.

Charles Liberman, M.D.
(Print or Type Name)

(Address) Winthrop, Mass. 6/16/ 1963

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 19 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass.

Received and filed JUN 18 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED, WIDOWED, DIVORCED, UNKNOWN Married

11 If married, widowed, or divorced HUSBAND of Ida Metz
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 73 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Retired Telephone Worker
(Kind of work done during most working life)

14 Industry or Business N.E. Tel & Tel Co

15 Social Security No. 16 BIRTHPLACE (City) East Boston Mass
(State or country)

17 NAME OF FATHER James Reagan

18 BIRTHPLACE OF FATHER (City) Boston Mass
(State or country)

19 MAIDEN NAME OF MOTHER Johanna Hurley

20 BIRTHPLACE OF MOTHER (City) Toledo Ohio
(State or country)

21 Informant Ida Reagan
(Address)

33 Hutchinson St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph S. Scramm (Signature of Agent of Board of Health or other)

Health Officer June 18-63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

V V V

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.



STANDARD CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. Winthrop Community Hospital

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Abraham Schwartz
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a
U. S. War Veteran. WW1
if so specify WAR)

(a) Residence. No. 18 Dolphin Ave
(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 16 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Nov. 1961 to June 16, 1963

I last saw him alive on June 16, 1963, death is said to
have occurred on the date stated above, at 4:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

INTERVAL
BETWEEN
ONSET AND
DEATH
3 hrs.

Due To Hypertension

1 1/2 yrs

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Myocardial Infarction 4 months
DIABETES MELLITUS 1 yr.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS. Date 6/16/1963

6 Meretzer Cemetery Woburn
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 17 1963

7 NAME OF FUNERAL DIRECTOR Levine Chapel, Inc.
ADDRESS 470 Harvard St., Brookline

Received and filed JUN 18 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married

10a If married, widowed or divorced
HUSBAND of Bessie Goldbin
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: Accountant
(Kind of work done during most of working life)

14 Industry or Business: Army Base

15 Social Security No. 011-03-2304

16 BIRTHPLACE (City) New York
(State or country)

17 NAME OF FATHER Isadore Schwartz

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME Yetta (unknown)
OF MOTHER

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Bessie Schwartz
(Address) 18 Dolphin Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Lirianne (M)
(Signature of Agent of Board of Health or other)

Health Officer June 17-1963
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

CANNOT BE
LEARNED

JUN 13 1963 AM

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3.62-932695

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PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

115

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME GRACE PERRONE (MANCUSO)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 107 Bowdoin Street
(Usual place of abode) St. Winthrop, Massachusetts
(If nonresident, give city or town and State)

Length of stay: In place of death..... years..... 1 months 20 days. In place of residence..... 25 years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH June 20, 1963
(Month) (Day) (Year)

9 SEX 10 COLOR 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN
Female White widowed

4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)
Cerebro-vascular accident. Fracture of
femur.

12 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Leonard Perrone
(Husband's name in full)

5 Accident, suicide, or homicide (specify) Accident.

13 AGE 77 Years 7 Months 24 Days
If under 24 hours
..... Hours Minutes

Date and hour of injury May 1, 1963.

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

IF ACCIDENTAL, was injury causally related to the death? Yes.

Where did injury occur? Winthrop, Massachusetts.
(City or town and State)

15 Industry or Business: At Home

Did injury occur in or about home, on farm, in industrial place, or in
public place? Home.

16 Social Security No. None

Manner of injury Accidental fall to floor.
(How did injury occur?)

17 BIRTHPLACE (City)
(State or country) Italy

Nature of injury Fracture of femur.

18 NAME OF FATHER Salvatore Mancuso

While at work? Was autopsy performed? No.

19 BIRTHPLACE OF FATHER (City)
(State or country) Italy

6 Was disease or injury in any way related to occupation of deceased?

20 MAIDEN NAME OF MOTHER Grazia Rinaldi

(Signed) Michael A. Luongo, M.D.

21 BIRTHPLACE OF MOTHER (City)
(State or country) Italy

(Print or Type Name)

(Address) Boston Date 6/20 1963

22 Informant (Address) Frank Perrone
109 Bowdoin St Winthrop

7 Place of Burial or Cremation. Winthrop
DATE OF BURIAL June 24 1963

8 NAME OF FUNERAL DIRECTOR Ernest P. Maggiano

ADDRESS 147 WINTHROP ST Winthrop

Received and filed JUN 21 1963

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

(Registrar)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No.

116

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

No. 243 MAIN ST.

2 FULL NAME OLIVER J BROCK
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 263 MAIN ST
(Usual place of abode) ST. WINTHROP MASS
(City or town and State)

Length of stay: In place of death 51 years.....months.....days. In place of residence 51 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 21 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 19, 1963, to June 21, 1963
I last saw him alive on June 19, 1963, death is said to
have occurred on the date stated above, at 1 am.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

(b) Arterio Sclerosis

(c) Arterio Sclerotic Heart Disease

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis Clinexam

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Louis E. Schwaartz, M. D.
(Print or Type Name)

(Address) 14 Beacon St. Boston Date June 21 1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 24 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed JUN 21 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)
MALE WHITE MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of MARY DOYLE
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 79 Years.....Months.....Days If under 24 hours
Hours Minutes

13 Usual Occupation: RETIRED WAITER
(Kind of work done during most of working life)

14 Industry or Business: HOTEL

15 Social Security No. 021-05-2922A

16 BIRTHPLACE (City) FITCHBURG
(State or country) MASS

17 NAME OF FATHER JAMES BROCK

18 BIRTHPLACE OF FATHER (City) GLASGOW
(State or country) SCOTLAND

19 MAIDEN NAME OF MOTHER MARY SMITH.

20 BIRTHPLACE OF MOTHER (City) ENGLAND
(State or country)

21 Informant MRS MARY BROCK
(Address) 263 MAIN ST WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING RECEIVED
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

Registered No. 117

1 PLACE OF DELIVERY
Suffolk (County)
Wentworth (City or Town)
No. Wentworth Community Hospital St. } (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 NAME OF FETUS (if given) Baby Boy Santoro

3 DATE OF DELIVERY June 24 1963
(Month) (Day) (Year)

4 SEX Male ☒ Female ☐ Undetermined ☐ 5 COLOR (if determined) W 6 THIS BIRTH (Check one) Single ☒ Twin ☐ Triplet ☐ 7 IF MULTIPLE BIRTH, BORN: 1st ☐ 2nd ☐ 3rd ☐

8 FULL NAME Angelo Santoro FATHER
14 MAIDEN NAME Ida Santoro MOTHER
PRESENT NAME Ida Laurano

9 RESIDENCE, NO. 178 Bennington STREET
CITY OR TOWN East Boston STATE Mass

15 RESIDENCE, NO. 178 Bennington STREET
CITY OR TOWN East Boston STATE Mass

10 COLOR OR RACE white 11 AGE AT TIME OF THIS DELIVERY 48 (Years)
16 COLOR OR RACE white 17 AGE AT TIME OF THIS DELIVERY 37 (Years)

12 PLACE OF BIRTH East Boston Mass
(City or Town) (State or country)
18 PLACE OF BIRTH E. Boston Mass
(City or Town) (State or country)

13 OCCUPATION Clerk, U.S. Post Office
19 INFORMANT Ida Santoro

20 PREVIOUS DELIVERIES TO MOTHER (Do not include this fetus) 6 (a) How many children are now living? 6 (b) How many children were born alive but are now dead? none (c) How many previous fetal deaths of ANY gestation age? none

21 LENGTH OF PREGNANCY completed weeks 27 22 Weight Lb. 1/2 Oz. OF FETUS (or Grams) 23 WHEN DID FETUS DIE? Before Labor During Labor or Delivery Unknown ☒ 24 AUTOPSY Yes No ☒

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Unknown
Due To (b)
Due To (c)

I HEREBY CERTIFY that this delivery occurred on the date stated above at 12:35 p.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:
Louis E. Schaffa M.D.

OTHER SIGNIFICANT CONDITIONS None
26 Holy Cross MAIDEN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 6/26 1963

27 NAME OF FUNERAL DIRECTOR Anthony P. Rando
ADDRESS 9 Chelsea St & Boston

Received and filed JUN 27 1963 19
(Registrar)

A TRUE COPY ATTEST:
I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Liviani
(Signature of Agent of Board of Health or other)
J. O. June 26, 1963
(Official Designation) (Date of Issue of Permit)

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 113

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Mount's Convalescent Home

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

104 Highland Ave.

2 FULL NAME HENRY J. Keeler

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

No

(a) Residence. No. 135 CRYSTAL Ave.

(Usual place of abode)

St. Revere

(If nonresident, give city or town and State)

Length of stay: In place of death 6 years 6 months 6 days. In place of residence 58 years 6 months 6 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 25 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
MARCH 10 1953, to JUNE 25 1963

I last saw him live on JUNE 21 1963, death is said to

have occurred on the date stated above, at 3 40 A. m.

INTERVAL
BETWEEN
ONSET AND
DEATH

4 YRS

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF
PROSTATE GLANDDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify.

(Signed) Joseph J. Paarmo, M. D.

(Address) 20 CRESCENT AVE REVERE Date JUNE 25 1963

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 6-27-1963

7 NAME OF FUNERAL DIRECTOR ARTHUR S. PORCELLA

ADDRESS 876 Winthrop Ave. Revere

Received and filed JUN 27 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Male White MARRIED
WIDOWED
or DIVORCED Widowed10a If married, widowed, or divorced
HUSBAND of Agnes Doty
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Retired - Carpenter
(Kind of work done during most of working life)14 Industry
or Business:

15 Social Security No. 032-16-7063

16 BIRTHPLACE (City) New York
(State or country) N.Y.

17 NAME OF FATHER George Keeler

18 BIRTHPLACE OF FATHER (City) Thrognock
(State or country) New York

19 MAIDEN NAME OF MOTHER Emily J. TURNER

20 BIRTHPLACE OF MOTHER (City) Rye-
(State or country) N.Y.21 Informant Charles Keeler
(Address) 135 Crystal Ave. RevereI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Suran (3)

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

June 27 1963
(Date of Issue of Permit)

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . . — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death. Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteenth, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

119

STANDARD
CERTIFICATE OF DEATH

Registered No.

PLACE OF DEATH

Suffolk
(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

George Kelley

PHYSICIAN — IMPORTANT

2 FULL NAME.....
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) no(a) Residence. No. 80 Sagamore St.
(Usual place of abode)St. Revere Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....20 days. In place of residence.....30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 27 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
June 20 1963 to June 27 1963
Last saw him alive on June 27 1963, death is said to
have occurred on the date stated above, at 10:50 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

INTERVAL
BETWEEN
ONSET AND
DEATH

2 hrs.

Due To Duodenal ulcer 20 days

(b) Gastroenterostomy 1 week
ENTEROSTOMYDue To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John H. Crandon, M. D.

JOHN H. CRANDON
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date June 27 1963

Puritan Lawn Peabody

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 11, 1963 19

7 NAME OF FUNERAL DIRECTOR J. Vincent Murray
ADDRESS Revere

Received and filed JUN 28 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED or DIVORCED10a If married, widowed, or divorced
HUSBAND of Elizabeth Burke
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Inspector
(Kind of work done during most of working life)

14 Industry or Business: Edison Co.,

15 Social Security No. 012 07 4861

16 BIRTHPLACE (City) Boston Mass.
(State or country)

17 NAME OF FATHER Michael Kelley

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary Ryan

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Elizabeth Kelley
(Address) 80 Sagamore St. RevereI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Joseph E. ...
(Signature of Agent of Board of Health or other)Health Officer June 28, 1963
(Official Designation) (Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF DISCHARGE.

ORGANIZATION AND OUTFIT

SERVICE NUMBER.

RULES OF PRACTICE

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 130

Suffolk
(County)

Winthrop
(City or Town)

No. 24 Tileston Rd.

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Raffaele Famiglietti
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) no

(a) Residence. No. 24 Tileston Road
(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death 16 years months days. In place of residence 16 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 28 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 20 to June 28 1963
I last saw him alive on June 28 1963 death is said to have occurred on the date stated above, at 1:30 p.m.

INTERVAL
BETWEEN
ONSET AND
DEATH
2 hrs

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Chronic Bronchiectasis
(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Marion C. Sabia, M. D.

(Print or Type Name)

(Address) 241 Main St. Date June 24 1963

6 St. Michael Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 2, 1963

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
147 Winthrop St., Winthrop

ADDRESS

Received and filed JUL 1 - 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN widowed

11 If married, widowed, or divorced
HUSBAND of Antonette Salerno
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 82 Years 1 Months 12 Days If under 24 hours Hours Minutes

13 Usual Occupation: Retired Storekeeper
(Kind of work done during most working life)

14 Industry or Business: Retail Grocery

15 Social Security No. 033-26-4468

16 BIRTHPLACE (City) Gesualdo (State or country) Italy

17 NAME OF FATHER Raffaele Famiglietti

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Angela Maria

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant (Address) Dr. Joseph A. Famiglietti
227 Court Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Surdum (Signature of Agent of Board of Health or other)

Health Officer July 1, 1963 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

RECEIVED



The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

JUL 1 1963 AM

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT OF - TC 121
(City or Town making this return)

SUFFOLK

(County)

BOSTON

(City or Town)



STANDARD
CERTIFICATE OF DEATH

Registered No. 05227

MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Baby Girl Basch
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 210 Shore Drive
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 10, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That attended deceased from
May 10, 1963, to May 10, 1963

I last saw her alive on May 10, 1963, death is said to
have occurred on the date stated above, at 2:10 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PREMATUREITY

INTERVAL
BETWEEN
ONSET AND
DEATH

1 1/3 HOURS

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

PULMONARY ANECTASIS

MONTHS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) *Charles L. Cloy*, M. D.Charles L. Cloy, M.D.
(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date May 10, 1963

6 Gethsemane Cemetery Boston, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 15, 1963

7 NAME OF Eastman Funeral Service Inc.
FUNERAL DIRECTOR

ADDRESS 896 Beacon St., Boston, Mass.

Received and filed MAY 17 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Single

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 1 Years, Months, Days 1 under 24 hours
Hours, Minutes 20

13 Usual Occupation: (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

17 NAME OF FATHER C.N.B.L.

18 BIRTHPLACE OF FATHER (City) C.N.B.L.
(State or country)

19 MAIDEN NAME OF MOTHER Ann P. Basch

20 BIRTHPLACE OF MOTHER (City) Winthrop, Mass.
(State or country)

21 Informant Ann P. Basch
(Address) 210 Shore Drive, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Richard Horman QW.
(Signature of Agent of Board of Health or other)

16585 5-15-63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Register



JUL 25 1963 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN
To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 05236

SUFFOLK

(County)

BOSTON

(City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{ (Was deceased a
U. S. War Veteran,
if so specify WAR)

2 FULL NAME Ruby H. Walton (Berry)

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 61 Washington Avenue
(Usual place of abode)

xx Winthrop, Massachusetts

(If nonresident, give city or town and State)

Length of stay: In place of death 1 years 26 months 26 days In place of residence 40 years 0 months 0 days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 14, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
March 18, 1963, to May 14, 1963

Last saw him alive on May 14, 1963, death is said to
have occurred on the date stated above, at 5:27P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gastrointestinal Hemorrhage 5 days

Due To (b) Esophageal and Gastric Varices years

Due To (c) Nutritional Chrrhosis years

OTHER SIGNIFICANT CONDITIONS Coronary Heart Disease years

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 5/15/ 19 63

Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 17 19 63

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed MAY 21 1963

Charles H. Mackie

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN ☐ ☐ ☐ ☐ ☐

11a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Frank E. Walton (Husband's name in full)

12 DATE OF BIRTH Dec. 11 1889

AGE 73 Years 5 Months 3 Days If under 24 hours

14 Usual Occupation: Clerk (Kind of work done during most of working life)

15 Industry or Business: Cemetery Office

16 Social Security No. 018-16-4495

17 BIRTHPLACE (City) West Medway (State or country) Massachusetts

18 NAME OF FATHER Charles Berry

19 BIRTHPLACE OF FATHER (City) Unable to obtain (State or country)

20 MAIDEN NAME OF MOTHER Lillie MacIntosh

21 BIRTHPLACE OF MOTHER (City) Unable to obtain (State or country)

22 Informant (Address) Marguerite Walton 61 Washington Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

16598 5-16-65

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

R-301

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The Commonwealth of Massachusetts

123

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSOUT-OF-TOWN
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 05382

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



No. BETH ISRAEL HOSPITAL

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARY Dinubla

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, No
if so specify WAR)(a) Residence. No. 293 Bowdoin St. Winthrop, Massachusetts
(Usual place of abode)

(City or town and State)

Length of stay: In place of death. years. months. 4 days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 20 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 6, 1963, to May 20, 1963.

I last saw her alive on May 20, 1963, death is said to have occurred on the date stated above, at 4:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia Lobar

(b) Intestinal Obstruction

(c) Diverticulitis, sigmoid colon

OTHER SIGNIFICANT CONDITIONS Pulmonary Tuberculosis

INTERVAL
BETWEEN
ONSET AND
DEATH

10 days

14 days

?

20 yrs

Was autopsy performed? No

What test confirmed diagnosis? operation - 5-7-63

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Russell F. Minton, Jr., M. D.

Russell F. Minton, Jr.

(Print or Type Name)

(Address) Beth Israel Hosp. Date 5-20-1963

New Calvary Boston

Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 25 1963

7 NAME OF FUNERAL DIRECTOR Frederick J. MacGrath

ADDRESS East Boston

Received and filed MAY 23 1963

Charles H. Mackie

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Rocco Di Nubla (Husband's name in full)

12 AGE 76 Years Months Days 13 Usual Occupation Housework (Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No. CN61

16 BIRTHPLACE (City or State or country) Boston, MASS.

17 NAME OF FATHER Daniel Ring

18 BIRTHPLACE OF FATHER (City or State or country) Boston MASS.

19 MAIDEN NAME OF MOTHER Catherine Flaherty

20 BIRTHPLACE OF MOTHER (City or State or country) Boston MASS.

21 Informant Robert Di Nubla

(Address) 293 Bowdoin St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F. P. Graca B 05380

(Signature of Agent of Board of Health or other)

May 21, 1963

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

R-301

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PLACE OF DEATH

Suffolk
(County)Boston
(City or Town)No. New England Deaconess HospitalKEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHRegistered No. 05761(If death occurred in a hospital or institution,
give its NAME instead of street and number)
PHYSICIAN — IMPORTANT2 FULL NAME Mr. Augustus L. Norris

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence, No. 37 Bay View Ave.
(Usual place of abode)St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, 6 years, 6 months, 6 days. In place of residence 56 years, 6 months, 6 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 31, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
May 25, 1963 to May 31, 1963I last saw him live on May 31, 1963 death is said to
have occurred on the date stated above, at 1:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY ARTERY OCCLUSION.(b) ARTERIOSCLEROTIC HEART DISEASE(c) DIABETES MELLITUSOTHER
SIGNIFICANT
CONDITIONSINTERVAL
BETWEEN
ONSET AND
DEATH1 wk.2 mo11 yrs.Was autopsy performed? Yes
What test confirmed diagnosis? AUTOPSY.5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) C. K. Gorman M. D.

(Print or Type Name)

(Address) N.E. DEACONESS HOSP. Date 5th May 19636 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)DATE OF BURIAL June 3, 19637 NAME OF FUNERAL DIRECTOR Arthur J. O'MaleyADDRESS Winthrop, Mass.Received and filed JUN 4 1963 19.Mary E. Manning

(Registrar)

A TRUE COPY ATTEST:

ASSY

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of Ruth Gilbert

(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)12 AGE 57 Years, _____ Months, _____ Days
If under 24 hours
_____ Hours, _____ Minutes13 Usual Occupation: Welder
(Kind of work done during most of working life)14 Industry or Business: U. S. Arsenal15 Social Security No. 012-14-442316 BIRTHPLACE (City) Winthrop
(State or country) Mass17 NAME OF FATHER Augustus W. Norris18 BIRTHPLACE OF FATHER (City) Halifax
(State or country) Nova Scotia19 MAIDEN NAME OF MOTHER Ellen G. Lane20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Mass21 Informant Ruth Norris(Address) 37 Bay View Ave.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

67520 June 1, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane:
City Registrar

RECEIVED



JUL 25 1963 PM

The Commonwealth of Massachusetts

125

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSuffolk
(County)Chelsea
(City or Town making this return)COPY OF
CERTIFICATE OF DEATH

Registered No. 346

No. Chelsea Memorial Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Mary Douglas

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR,(a) Residence. No. 46 Loring Road
(Usual place of abode)Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH June 14, 1963
(Month) (Day) (Year)8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Single4 I HEREBY CERTIFY, That I attended deceased from
May 1, 1963, to June 14, 1963
I last saw him alive on June 14, 1963, death is said to
have occurred on the date stated above, 4 p.m.

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 88 Years 1 Months 11 Days If under 24 hours
Hours Minutes13 Usual Occupation Bookkeeper
(Kind of work done during most working life)

14 Industry or Business Publishing Co.

15 Social Security No. 013-07-8487

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

17 NAME OF FATHER Alexander Douglas

18 BIRTHPLACE OF FATHER (City) Scotland
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Alexander

20 BIRTHPLACE OF MOTHER (City) Scotland
(State or country)21 Informant Margery Fenton
(Address) 39 Lovejoy Rd., Andover, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED June 16, 1963

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH(a) Arteriosclerotic heart
Due To disease 1 mo.

(b) Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS Lobar pneumonia 2 wks.

Was autopsy performed? no
What test confirmed diagnosis? x-ray & clinical5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles J. Ferrera, M. D.

(Address) 154 Bennington St. 6/14/63
East Boston, Mass.6 Winthrop, Mass. Winthrop, Mass.
Place of burial or cremation (City or town)

DATE OF BURIAL June 17, 1963

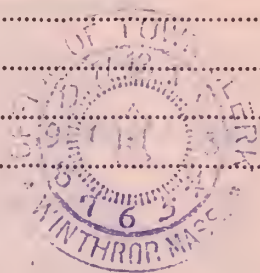
7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed AUG 5 1963

(Registrar of City or Town where deceased resided)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



AUG 11 5 1963 AM

The Commonwealth of Massachusetts

126

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Gloucester

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

No. Addison Gilbert Hospital

Mabel Sophia Doleman

2 FULL NAME. (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR.(a) Residence. No. 126 Court Road Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....3.....days. In place of residence.....56.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 28, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased on
April 56, 1963 to June 28, 1963
I last saw him alive on June 28, 1963 death is said to
have occurred on the date stated above, at 4:55PINTERVAL
BETWEEN
ONSET AND
DEATHDEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebral vascular thrombosis

Due To (b) Arteriosclerosis 5 dys.

Due To (c)

OTHER SIGNIFICANT CONDITIONS Aplastic anemia 1 mo.

Was autopsy performed? No
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) C. Bruce Brown, M. D.
(Address) Rockport, Mass. Date 6/28, 19636 Winthrop Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 1, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed JUL 17 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED Married10a If married, widowed, or divorced
HUSBAND of John Edgar Doleman
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 61 Years 0 Months 0 Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 010-05-8378B

16 BIRTHPLACE (City) Lockport, N.S.
(State or country) Canada

17 NAME OF FATHER George H. Hiltz

18 BIRTHPLACE OF FATHER (City) Lockport, N.S.
(State or country) Canada

19 MAIDEN NAME OF MOTHER Ada Letilia Crowell

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)21 Informant John Doleman
(Address) 50 Court St. WinthropA TRUE COPY Fred J. Tyrav
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED July 1, 1963

T. V. H. ✓



SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....

JUL 17 1983 AM

Suffolk

(County)

Revere

(City or Town)

Ocean View Manor

No.

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Revere

(City or Town making this return)

COPY OF
 CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution,
 St. { give its NAME instead of street and number)

2 FULL NAME **Harry Clinton Beless**
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
 U. S. War Veteran, **No**
 if so specify WAR.

(a) Residence. No. **338 Pleasant**
 (Usual place of abode)

St. **Winthrop**
 (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **June 29, 1963**
 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I **declared deceased from**
August 60 to June 29, 63
 I last saw him alive on **June 29, 63** death is said to
 have occurred on the date stated above, at **9:15A.** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cancer of Breast**

INTERVAL
 BETWEEN
 ONSET AND
 DEATH
1 yr.

Due To
 (b)

Due To
 (c)

OTHER
 SIGNIFICANT
 CONDITIONS

No

Was autopsy performed? **Clinical, Pathological**
 What test confirmed diagnosis? **no**

5 Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify

(Signed) **Charles Liberman** M. D.

(Address) **Winthrop 6/30 63**

Winthrop Cemetery Winthrop
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 2, 63**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**

ADDRESS **174 Winthrop St., Winthrop**

Received and filed **JUL 12 1963**

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed or divorced
 HUSBAND of **Ellen Kendall Farrand**
 (Give maiden name of wife in full)

(or) WIFE of.....
 (Husband's name in full)

12 AGE **80** Years **1** Months **15** Days If under 24 hours
 Hours.....Minutes

13 Usual Occupation: **Retired salesman**
 (Kind of work done during most working life)

14 Industry or Business: **Hospital supplies**

15 Social Security No. **012-03-7968**

16 BIRTHPLACE (City) **Needham**
 (State or country) **Mass.**

17 NAME OF FATHER **John Henry Beless**

18 BIRTHPLACE OF FATHER (City) **Needham**
 (State or country) **Mass.**

19 MAIDEN NAME OF MOTHER **Mary Lee**

20 BIRTHPLACE OF MOTHER (City) **Brookline**
 (State or country) **Mass.**

Theodore L. Beless

21 Informant (Address) **338 Pleasant St., Winthrop**

A TRUE COPY

ATTEST: **Joseph P. Sullivan**
 (Registrar of City or Town where death occurred)

DATE FILED **July 2, 1963**

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



JUL 12 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

128

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No.

No. 587 Pleasant Street (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Roslyn May Paro (Doane)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO.(a) Residence. No. 587 Pleasant Street
(Usual place of abode) St. (If nonresident, give city or town and State)

Length of stay: In place of death. 3 years. months. days. In place of residence. 58 years. 1 months. 23 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 1 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw him alive on 19....., death is said to
have occurred on the date stated above, at 2:40 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to natural causes, probably
(b) due to acute coronary
(c) occlusion on basis of historyINTERVAL
BETWEEN
ONSET AND
DEATHOTHER SIGNIFICANT CONDITIONS Winthrop Board of Health
Charles Liberman, M.D.Was autopsy performed?
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/1/63

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 3, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUL 2 - 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Alfred Roy Paro
(Husband's name in full)12 AGE 58 Years 1 Months 23 Days If under 24 hours
Hours. Minutes13 Usual Occupation: saleslady
(Kind of work done during most working life)

14 Industry or Business: retail merchandise

15 Social Security No. 019-23-7263

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts17 NAME OF FATHER Doane
Benjamin Stanwood18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Massachusetts19 MAIDEN NAME OF MOTHER Donahue
Frances Agnes20 BIRTHPLACE OF MOTHER (City) England
(State or country)21 Informant Mrs. Edward C. Feeney
(Address) 218 Court Road, Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (Not)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

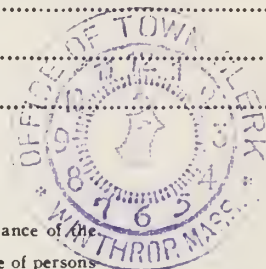
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUL 2 1963 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 129

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. 106 PUTNAM ST

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME VITO PETRALIA
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(a) Residence. No. 106 PUTNAM ST
(Usual place of abode)St. WINTHROP
(City or town and State)

Length of stay: In place of death 33 years.....months.....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 1 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw him alive on JULY 1, 1963 death is said to
have occurred on the date stated above, at 5:50 P.M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to
(b) natural causes, probably
(c) acute coronary occlusion
on basis of history.OTHER
SIGNIFICANT
CONDITIONSWinthrop Board of Health
Charles Liberman M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) Charles Liberman, M.D.
CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/3/1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 5 1963

7 NAME OF FUNERAL DIRECTOR MARGIE W. KIRBY

ADDRESS WINTHROP

Received and filed JUL 3 - 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN MARRIED11 If married, widowed, or divorced
HUSBAND of ANGELA LAMPASONA
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 74 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation BARBER (RETIRED)
(Kind of work done during most of working life)

14 Industry or Business BARBER SHOP

15 Social Security No.

16 BIRTHPLACE (City) ITALY
(State or country)

17 NAME OF FATHER PAUL PETRALIA

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER JOSEPHINE LOLONGENIO

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)

21 Informant PAUL PETRALIA

(Address) 106 PUTNAM ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Liriani
(Signature of Agent of Board of Health or other) (H3)Health Officer July 3, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUL 3 1963 AM

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 130

No. Winthrop Community Hospital (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Emilio Staffieri (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 17 Chisholm St. St. Everett Mass (If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence, 30 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 1 1963 (Month) (Day) (Year)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

I HEREBY CERTIFY That I attended deceased from Jan. 1955 to JULY 1 1963 I last saw him alive on JULY 1 1963, death is said to have occurred on the date stated above, at 1:30 p.m.

11 If married, widowed, or divorced HUSBAND of Louise Bonotti (Give maiden name of wife in full)

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH 24°

(b) Chr. Coronary Artery Disease 104°

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? NO TRANSAMINASE What test confirmed diagnosis? TRANSAMINASE - EKG - L.D.H.

5 Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signature) D. Thomas Staffieri M. D. D. Thomas STAFFIERI (Print or Type Name)

(Address) 21 BREED ST. Date July 1 1963

6 Holy Cross Cemetery, Malden (City or Town)

DATE OF BURIAL July 1 1963

7 NAME OF FUNERAL DIRECTOR Frederick G. Gass

ADDRESS 65 Clark St. Everett

Received and filed JUL 2 - 1963 19

(Registrar)

(or) WIFE of (Husband's name in full)

12 AGE 65 Years, Months, Days If under 24 hours Hours, Minutes

13 Usual Occupation: Cleaner (Kind of work done during most working life)

14 Industry or Business: Self Employed

15 Social Security No. 028-109-9906

16 BIRTHPLACE (City) (State or country) Italy

17 NAME OF FATHER Luigi Staffieri

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Santa Famiglietti

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Louise Staffieri (Address) 17 Chisholm St. Everett

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Joseph E. Sullivan

(Signature of Agent of Board of Health or other)

Health Officer July 2 1963

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUL 2 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **131**

PLACE OF DEATH

SUFFOLK
(County)
WINTHROP
(City or Town)



No. **MOUNTS CONVALESCENT HOME** St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **ANTONIO BONACCORSO**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) **NO**

(a) Residence. No. **12 PLEASANT ST.**
(Usual place of abode)

St. **WINTHROP**
(City or town and State)

Length of stay: In place of death. . . years. **1** months. **6** days. In place of residence. **5** years. . . months. . . days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **JULY 2 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from **APRIL 1 1963** to **JULY 2 1963**

I last saw him alive on **APR 23 1963** death is said to have occurred on the date stated above, at **3:45 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
CARCINOMA HEAD & PANCREAS

INTERVAL BETWEEN ONSET AND DEATH
6 mos

Due To (b) **ARTERIO-VASCULAR DISEASE 2-3 yrs**

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? **No**

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) **G. Guy Grande** M. D.

(Print or Type Name)

(Address) **20 Saratoga St. East Boston** Date **July 2 1963**

Winthrop. Winthrop Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 5 1963**

7 NAME OF FUNERAL DIRECTOR **Frederick J. Magrath.**

ADDRESS **325 Chelsea St. East Boston.**

Received and filed **JUL 3 - 1963** 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word) **WIDOWER**

11 If married, widowed, or divorced HUSBAND of **Anna Cambria**
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE **89** Years. Months. Days If under 24 hours Hours Minutes

13 Usual Occupation **Contractor (Retired)**
(Kind of work done during most of working life)

14 Industry or Business: **Retired GENERAL CONTR.**

15 Social Security No. **None**

16 BIRTHPLACE (City) **Italy**
(State or country)

17 NAME OF FATHER **Nunzio Bonaccorso**

18 BIRTHPLACE OF FATHER (City) **Italy**
(State or country)

19 MAIDEN NAME OF MOTHER **Mary Cannabucci**

20 BIRTHPLACE OF MOTHER (City) **Italy**
(State or country)

21 Informant **Lillian Pirroni**

(Address) **12 Pleasant St. Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) **Health Officer** (Date of Issue of Permit) **July 3 1963**

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

132

PLACE OF DEATH

Suffolk (County)

WINTHROP (City or Town)



CERTIFICATE OF DEATH

Registered No.

No. WINTHROP *Convallescent Home*

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emily LaPorta (Sarno)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 147 WINTHROP ST. St. BOSTON
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 8 years months days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 2 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19 to 19

I last saw him alive on 7/1/63, death is said to
have occurred on the date stated above, at 9:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to
natural causes, probably

Due To (b) cerebral vascular
occlusion on basis of

Due To (c) history and previous
ailment.

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed Charles Liberman, M.D.
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Charles Liberman, M.D.
CHARLES LIBERMAN

(Address) WINTHROP, MASS Date 7/2/1963

6 St Michael's Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 6 1963

7 NAME OF FUNERAL DIRECTOR Ernest P. Lagano
ADDRESS 147 Wintrop St Wintrop

Received and filed JUL 8 - 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED Widowed

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Gracoma LaPorta
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years 3 Months 5 Days If under 24 hours
Hours Minutes

13 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. None

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER David Sarno

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER LOUISE ARICCA

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Mrs Margaret Martusci
(Address) 125 Ciccutt Rd Wintrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Siranni (Signature of Agent of Board of Health or other) (1963)

Health Officer July 5 1963
(Official Designation) (Date of Issue of Permit)

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteen, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall remove a human body and remove it from a town, from one cemetery and interment in another grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 133

No. 455 Shirley Street

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Phyllis Alexandra Savino (Kennedy)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.(a) Residence. No. 455 Shirley Street
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years months 7 days. In place of residence 45 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 4 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
October 1953 to July 4, 1963

I last saw her alive on July 2, 1963, death is said to

have occurred on the date stated above, at 9:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

(b) Hypertensive Arteriosclerotic

(c) Heart Disease

INTERVAL
BETWEEN
ONSET AND
DEATH

1 day

OTHER
SIGNIFICANT
CONDITIONS Diabetes Mellitus

2 yrs

Was autopsy performed? No

What test confirmed diagnosis? Clin. 201

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/5/1963

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 6, 1963

7 NAME OF
FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JUL 8 - 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the words)
MARRIED married

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Carl Savino
(Husband's name in full)12 AGE 60 Years 3 Month 29 Days If under 24 hours
Hours Minutes13 Usual Occupation: retired waitress
(Kind of work done during most working life)

14 Industry or Business: restaurant

15 Social Security No. 034-20-7876

16 BIRTHPLACE (City) East Boston
(State or country) Massachusetts17 NAME OF
FATHER Frank Alexander Kennedy18 BIRTHPLACE OF
FATHER (City) Rouses Point
(State or country) New York19 MAIDEN NAME
OF MOTHER Bernice May Oakes20 BIRTHPLACE OF
MOTHER (City) Charlestown
(State or country) Massachusetts21 Informant Carl Savino
(Address) 455 Shirley St. Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (H.B.)

(Official Designation) (Date of Issue of Permit) July 5, 1963

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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RECEIVED



JUL 18 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. **134**

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. **WINTHROP COMMUNITY HOSPITAL** St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Bernard Baldassaro**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) **No**(a) Residence. No. **84 Orient Ave., E. Boston** St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **JULY 5 1963**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased, from **6/1 1963**, to **7/5 1963**I last saw him alive on **7/5 1963**, death is said to have occurred on the date stated above, at **3:25 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **CIRRHOSIS OF LIVER**Due To **WITH JAUNDICE AND ASCITES**

Due To (c)

OTHER SIGNIFICANT CONDITIONS **LEUKEMIA - CHRONIC MYELOGENOUS**INTERVAL BETWEEN ONSET AND DEATH **6 mo.****1 mo****2 yrs**Was autopsy performed? **No**What test confirmed diagnosis? **CLINICAL**5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify(Signature) **Myron N. King** M. D.**MYRON N. KING MD**
(Print or Type Name)(Address) **W. Pleasant St.** Date **7/5 1963**6 Place of Burial or Cremation **Holy Cross Cemetery Malden** (City or Town)DATE OF BURIAL **July - 8 1963**7 NAME OF FUNERAL DIRECTOR **Lillian Catalano**ADDRESS **374 Broadway Som, Mass**Received and filed **JUL 8 1963** 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word) **Married**
MARRIED
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced **Esther Palazzo**
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of..... (Husband's name in full)

12 AGE **56** Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: **Steam Fitter**
(Kind of work done during most working life)14 Industry or Business: **City of Boston**15 Social Security No. **024-03-3187**16 BIRTHPLACE (City) **Boston**
(State or country) **Mass**17 NAME OF FATHER **Pasquale Baldassaro**18 BIRTHPLACE OF FATHER (City) **Italy**
(State or country)19 MAIDEN NAME OF MOTHER **Maria Martignetti**20 BIRTHPLACE OF MOTHER (City) **Italy**
(State or country)21 Informant **Esther Baldassaro**
(Address) **84 Orient Ave. E. B.**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer **July 6 1963**

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Copy

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
RECEIVED.....



JUL 8 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **135**

PLACE OF DEATH

SUSSEX
(County)

WINTHROP
(City or Town)

No. **5 Summit ave**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME **Kenneth R Silk**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, **No**
if so specify WAR)

(a) Residence, No. **5 Summit ave**
(Usual place of abode)

St. _____
(If nonresident, give city or town and State)

Length of stay: In place of death **12** years.....months.....days. In place of residence **22** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **July 9, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
I last saw h..... alive on....., 19....., death is said to
have occurred on the date stated above, at **7:10 A.M.**

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Death presumably due to**

Due To **natural causes,**
(b) **probably acute coronary**
(c) **occlusion on basis of**

OTHER history. **Winthrop Board of Health**
SIGNIFICANT CONDITIONS **Charles Liberman, M.D.**

Was autopsy performed? _____
What test confirmed diagnosis? _____

5 Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signature) **Charles Liberman, M.D.**
CHARLES LIBERMAN
(Print or Type Name)
(Address) **WINTHROP** Date **7/10/1963**

6 **Winthrop** **Winthrop**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 11, 1963**

7 NAME OF FUNERAL DIRECTOR **Ernest P. Baggiano**

ADDRESS **147 Winthrop St Winthrop**

Received and filed **JUL 10 1963**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN **Married**

11 If married, widowed or divorced
HUSBAND of **Margaret Silk (Poland)**
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

12 AGE **53** Years **8** Months **29** Days
If under 24 hours
Hours.....Minutes

13 Usual Occupation **Electrical Tester**
(Kind of work done during most working life)

14 Industry or Business **Electric Motors**

15 Social Security No. _____

16 BIRTHPLACE (City) **WINTHROP**
(State or country) **Mass**

17 NAME OF FATHER **Albert Silk**

18 BIRTHPLACE OF FATHER (City) **East Boston**
(State or country) **Mass**

19 MAIDEN NAME OF MOTHER **Delie Connolly**

20 BIRTHPLACE OF MOTHER (City) **Boston**
(State or country) **Mass**

21 Informant (Address) **Margaret Silk**
5 Summit ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Liberman
(Signature of Agent of Board of Health or other) **H.B.**

Health Officer **July 10, 1963**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

78 JUL 6 1908 RECEIVED U.S. DEPT. OF THE ARMY WASHINGTON 78 JUL 6 1908 RECEIVED U.S. DEPT. OF THE ARMY WASHINGTON

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **136**

PLACE OF DEATH

Suffolk
(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME Eva Alice (Mills) Knowlton
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)}

(a) Residence, No. 26 Amelia Ave
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 1 days. In place of residence 27 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH JULY 13 1963
(Month) (Day) (Year)

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED widow

4 I HEREBY CERTIFY That I attended deceased from
JULY 1 1963 to JULY 13 1963.
I last saw her alive on JULY 13 1963, death is said to
have occurred on the date stated above, at 4:45 p.m.

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of William Knowlton
(Husband's name in full)

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC DECOMPENSATION

INTERVAL
BETWEEN
ONSET AND
DEATH
2 WKS

Due To (b) ARTERIOSCLEROTIC
HEART DISEASE

Due To (c)

OTHER SIGNIFICANT CONDITIONS CARCINOMATOSIS
COLOSTOMY

IMD

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) A. M. Caplan M. D.
(PRINT OR TYPE SIGNATURE)

186 PRINCE STREET BOSTON Date 7-13-63

6 Place of Burial or Cremation Winthrop

DATE OF BURIAL July 14 1963

7 NAME OF FUNERAL DIRECTOR Howard J. Renolds
ADDRESS Winthrop Mass

Received and filed JUL 15 1963 19

(Registrar)

PARENTS

17 NAME OF FATHER Butler Mills
18 BIRTHPLACE OF FATHER (City) Stonington
(State or country) Maine

19 MAIDEN NAME OF MOTHER Laude Henderson

20 BIRTHPLACE OF MOTHER (City) New Hampshire
(State or country)

21 Informant Helen McOne
(Address) 25 Hollis Ave Winthrop, Maine

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Miriamme
(Signature of Agent of Board of Health or other)

Health Officer July 15 1963
(Official Designation) (Date of Issue of Permit)

T X

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

7 6 3 1
JUL 15 1963 AM
RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 137

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Kathleen D. O'Donnell
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence. No. 18 Cottage Ave
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 19 days. In place of residence, 20 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 15, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
March 62, to July 15, 1963
I last saw her alive on July 14, 1963, death is said to
have occurred on the date stated above, at 6:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Pancreas 6 mos.

Due To

(b)

Due To

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

OTHER SIGNIFICANT CONDITIONS Status post hysterectomy 4 mos.

Was autopsy performed?

What test confirmed diagnosis? Clinical, surgical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP Date 7/15/1963

6 St. Patricks, Lowell, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 17, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUL 15 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 45 Years, Months, Days If under 24 hours
Hours, Minutes13 Usual Occupation: School Teacher
(Kind of work done during most working life)

14 Industry or Business: Education

15 Social Security No.

16 BIRTHPLACE (City) Holyoke Mass
(State or country)

17 NAME OF FATHER John O'Donnell

18 BIRTHPLACE OF FATHER (City) Holyoke Mass
(State or country)

19 MAIDEN NAME OF MOTHER Anastasia Downing

20 BIRTHPLACE OF MOTHER (City) Lowell Mass
(State or country)21 Informant Esther O'Donnell
(Address)

18 Cottage Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (NEB)

Health Officer

(Date of Issue of Permit) July 15 1963

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No.

138

No. Mayflower Nursing Home

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran,
{if so specify WAR) NO

2 FULL NAME Alfred H. Queenan.

{(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 47 Loring Rd. Winthrop

(Usual place of abode)

St. { (If nonresident, give city or town and State)

Length of stay: In place of death. 1 years 4 months 3 days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH July 16, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Sept. 36, 1936, to July 16, 1963I last saw him alive on July 16, 1963, death is said to
have occurred on the date stated above, at 11:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage 1wk.

(b) Due To Hypertension and cerebral
Arteriosclerosis 4yrs

(c) Due To

OTHER SIGNIFICANT CONDITIONS None.

Was autopsy performed? NO

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS. Date 7/16/63

6 Cambridge Catholic Cambridge

Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 19 19637 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
ADDRESS 325 Chelsea St. East Boston.

Received and filed JUL 18 1963

(Registrar)

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED or DIVORCED10a If married, widowed, or divorced, give name of
HUSBAND of ANNA B. Burns
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years. Months. Days If under 24 hours
Hours. Minutes13 Usual Occupation: Shipfitter
(Kind of work done during most of working life)

14 Industry or Business: Retired E. Naval Yard

C.N. B. L.

15 Social Security No. East Boston
Mass.16 BIRTHPLACE (City) John Queenan
(State or country) Mass.

17 NAME OF FATHER John Queenan

18 BIRTHPLACE OF FATHER (City) East Boston,
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Catherine McCarthy

20 BIRTHPLACE OF MOTHER (City) Philadelphia
(State or country) Penn.21 Informant Mildred Queenan.
(Address) 47 Loring Rd. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUL 18 1963 PM

JUL 18 1963 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

139

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. BAYVIEW NURSING HOME STURGES

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME HELEN D. (BATTAGLIA) GALLAGHER

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 37 CLIFF AVE
(Usual place of abode)St. WINTHROP
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 17 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from Sept. 1961 to July 17 1963
I last saw him alive on July 17 1963, death is said to have occurred on the date stated above, at 11:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Breast 2 1/2 yrs

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Carcinomatosis to Lung 1 1/2 yrs

Was autopsy performed? No

What test confirmed diagnosis Clinical, Surgical, Pathological

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/19/1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 20 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W. ARBY

ADDRESS WINTHROP

Received and filed JUL 19 1963

John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN MARRIED

11 If married, widowed, or divorced

HUSBAND of

(or) WIFE of JOHNNY GALLAGHER
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 41 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation SOCIAL WORKER
(Kind of work done during most of working life)

14 Industry or Business: CITY OF BOSTON

15 Social Security No.

16 BIRTHPLACE (City) BOSTON
(State or country) MASS.

17 NAME OF FATHER SALVATORE BATTAGLIA

18 BIRTHPLACE OF FATHER (City) ITALY
(State or country)

19 MAIDEN NAME OF MOTHER FRANCES FISSICHELLA

20 BIRTHPLACE OF MOTHER (City) ITALY
(State or country)21 Informant JOHN J. GALLAGHER
(Address) 37 CLIFF AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siranni
(Signature of Agent of Board of Health or other)Health Officer July 19 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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JUL 19 1900

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

140

PLACE OF DEATH

Suffolk

Fowler
(County)Winthrop
(City or Town)

No.

May Flower Nursing Home

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Corradina Manceri

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No.

79 Pitcairn

St.

Riverside Mass

(Usual place of abode)

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATHJuly 17 - 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

July 13, 1962 to July 17, 1963

last saw him alive on July 17, 1963 death is said to

have occurred on the date stated above, at 10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC DECOMPENSATION

Due To
(b)Due To
(c)

arteriosclerotic heart disease

OTHER
SIGNIFICANT
CONDITIONS

CARDIAC FAILURE

INTERVAL
BETWEEN
ONSET AND
DEATH

2 days

1 yr

1 day

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature)

Andrea Catano

M. D.

ANDREA CATANO M.D.

(Print or Type Name)

(Address)

603 Broadway

Date

July 18, 1963

6 Place of Burial or Cremation

Holy Cross Malabar

(City or Town)

DATE OF BURIAL

July 19, 1963

7 NAME OF
FUNERAL DIRECTOR

Giaminis Sementi

ADDRESS

224 North St Boston

Received and filed

19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widowed

11 If married, widowed, or divorced

HUSBAND of

(or) WIFE of Achille Manceri
(Give maiden name of wife in full)
(Husband's name in full)

12

AGE 83 Years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation

House Wife

(Kind of work done during most of working life)

14 Industry
or Business

OWN HOME

15 Social Security No.

16 BIRTHPLACE (City)
(State or country)

Italy

17 NAME OF

FATHER

Lorenzo Presti

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER

Giuseppina Manceri

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

21 Informant

Joseph Manceri (son)

(Address)

79 Pitcairn St Riverside

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Not)

Health Officer

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **141**

Suffolk

(County)

Winthrop

(City or Town)

No. **Winthrop Community Hospital**

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME **Beatrice Macfarland**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR)}

(a) Residence. No. **46 Harbor View Ave. Winthrop**

(Usual place of abode)

St. _____
(If nonresident, give city or town and State)

Length of stay: In place of death _____ years _____ months **2** days. In place of residence **9** years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **JULY 18 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
JULY 16, 19**63**, to **JULY 18**, 19**63**
I last saw him alive on **JULY 18**, 19**63**, death is said to
have occurred on the date stated above, at **1:10 P.** m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **ACUTE MYOCARDIAL INSUFFICIENCY** **2 day**

Due To (b) **MITRAL STENOSES & REGURITATION** **10 yrs**

Due To (c) **RHEUMATIC HEART DISEASE** **50 yrs**

OTHER SIGNIFICANT CONDITIONS **NONE**

Was autopsy performed? **No**

What test confirmed diagnosis? **EKG & X-RAY**

5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify _____

(Signature) **Dorothy Cheney Appleton**, M. D.

DOROTHY CHENEY APPLETON
(Print or Type Name)

(Address) **197 Woodside Ave Winthrop, Mass** Date **7/18**, 19**63**

6 **Woodlawn Crematory Everett, Mass**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 22, 1963**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**

ADDRESS **174 Winthrop St. Winthrop**

Received and filed **JUL 19 1963**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **female** 9 COLOR **white** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)
(or) WIFE of **Edwin Curtis Macfarland**
(Husband's name in full)

12 AGE **68** Years **6** Months **12** Days If under 24 hours
Hours _____ Minutes _____

13 Usual Occupation: **Hotel Clerk**
(Kind of work done during most working life)

14 Industry or Business: **Hotel Services**

15 Social Security No. **030 03 5630**

16 BIRTHPLACE (City) **Marlboro, Mass.**
(State or country)

17 NAME OF FATHER **Stephen E. Simmons**

18 BIRTHPLACE OF FATHER (City) **Framingham, Mass.**
(State or country)

19 MAIDEN NAME OF MOTHER **Minnie E. Spofford**

20 BIRTHPLACE OF MOTHER (City) **Unknown Weyland, Mass.**
(State or country)

21 Informant **Edwin E. Macfarland (son)**
(Address)

46 Harbor View Ave. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Edwin E. Macfarland
(Signature of Agent of Board of Health or other)

Health Officer **July 19, 1963**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUL 19 1963 AM

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 142

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME Hazel B (Thompson) Magnuson
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
(if so specify WAR)(a) Residence. No. 100 Terrace Ave.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death. years months 10 days. In place of residence. years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 19 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
6/26 1963, to 7/19 1963
I last saw her alive on 7/19 1963, death is said to
have occurred on the date stated above, at 10:00 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) EMBOLISM BOTH PULMONARY
ARTERIESINTERVAL
BETWEEN
ONSET AND
DEATH

15 MIN

Due To POST OPERATIVE RESECTION 2 1/2 IN
(b) OF ASCENDING COLONDue To
(c) ULCER OF DUODENUM
OTHER SIGNIFICANT CHRONIC CHOLECYSTITIS & LITHIASIS
CONDITIONS HINTUS HERNIAWas autopsy performed? YES
What test confirmed diagnosis? AUTOPSY5 Was disease or injury in any way related to occupation of deceased NO
If so, specify(Signed) Myron N. King, M. D.
MYRON N. KING
(PRINT OR TYPE SIGNATURE)

(Address) 22 PLEASANT ST. Date 7/20 1963

6 Place of Burial or Cremation Winthrop
DATE OF BURIAL Jul. 19 637 NAME OF FUNERAL DIRECTOR
ADDRESS

Received and filed JUL 22 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED Married10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Arnold Magnuson
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 9 Months 12 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Unemployed

15 Social Security No. 022-14-1202

16 BIRTHPLACE (City) Boston
(State or country) MASS

17 NAME OF FATHER John A. Thompson

18 BIRTHPLACE OF FATHER (City) France
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Riely

20 BIRTHPLACE OF MOTHER (City) New York City
(State or country) New York21 Informant Arnold Magnuson
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Falah E. Sirisanni
(Signature of Agent of Board of Health or other) (H79)
Health Officer July 23 1963
(Official Designation) (Date of Issue of Permit)

T J V

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUL 22 1963

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **143**

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)



No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Marion (Jones) Leonard
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 55 Washington Ave.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years months 7 days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH July 28 1963
(Month) (Day) (Year)

8 SEX Female

9 COLOR White

10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widowed

4 I HEREBY CERTIFY, That I attended deceased from
July 21 1963, to July 28 1963

10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

I last saw him alive on July 27 1963, death is said to
have occurred on the date stated above, at 7:00 A. m.

(or) WIFE of Fred M. Leonard
(Husband's name in full)

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH

(a) ACUTE MYOCARDIAL INSUFFICIENCY

12 HRS

Due To (b) HYPERTENSIVE HEART DISEASE

5 YRS

Due To (c) HYPERTENSION

10 YRS

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? LABORATORY & EKG

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Dorothy Cheney Appleton, M. D.
DOROTHY CHENEY APPLETON
(PRINT OR TYPE SIGNATURE)

(Address) 77 Woodside Ave. Date 7/30 1963
Winthrop, Mass.

6 Winthrop
Place of Burial or Cremation July 30 1963
DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR Howard S. Arnold
ADDRESS Winthrop, Mass.

Received and filed July 30 1963

(Registrar)

PARENTS

17 NAME OF FATHER William Jones

18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country) Labrador

19 MAIDEN NAME OF MOTHER Mary Simicks

20 BIRTHPLACE OF MOTHER (City) Labrador
(State or country)

21 Informant Inez L. Brown
(Address) 74 Dartmouth Ave. Needham Heights.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Shades Office July 30 1963
(Official Designation) (Date of Issue of Permit)

VOL

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance, whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

Suffolk

(County)

Winthrop Mass.

(City or Town)



JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 144

No. Winthrop Community Hospital (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

Aaron Gurwitz

PHYSICIAN — IMPORTANT

2 FULL NAME. Aaron Hurwitz AKA GURWITZ (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 62 Pleasant St. St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 30 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
SEPT 16 1959 to JULY 30 1963
I last saw him alive on JULY 30 1963, death is said to
have occurred on the date stated above, at 5:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF THE PROSTATE

WITH METASTASIS TO

(b) RIBS & LUNGS

Due To (c) OTHER SIGNIFICANT CONDITIONS

ARTERIO SCLEROSIS -
GENERALIZED

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & X-ray.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron H. King M.D. M. D.
MYRON MYKING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) NEW PLEASANT ST. JULY 30 1963
New Montford Mass. Fanningdale h.l.

6 Place of Burial or Cremation (City or Town)
DATE OF BURIAL Aug 1 1963

7 NAME OF FUNERAL DIRECTOR Henry Levine
ADDRESS Brookline, Mass

Received and filed JUL 31 1963 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word)
MARRIED MARRIED
WIDOWED WIDOWED
or DIVORCED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Celia Host
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years 4 Months 8 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Salesman Macy's
(Kind of work done during most of working life)

14 Industry or Business: Metal Work

15 Social Security No. 057-09-1680

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Abraham Hurwitz
(Curwitz)

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Leah Siegel

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant (Address) AL Hurwitz
62 Pleasant St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)

Health Officer July 30 1963
(Official Designation) (Date of Issue of Permit)

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92562

Medical examiner notified of person's decline

5/7/63
J. H. King

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSMEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 145

No. 78 Locust Street, Winthrop

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME ELLEN Anne DEL TERGO

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO(a) Residence. No. 78 Locust Street, Winthrop
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 31, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Endocardial fibro-elastosis.
Congestive heart failure.

5 Accident, suicide, or homicide (specify)

Date and hour of injury19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did
Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?

(Specify type of place)

Manner of

Injury

(How did injury occur?)

Nature of

Injury

While at work?Was autopsy performed? Yes.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.

Michael A. Luongo, M. D.

(Address) Boston (Print or Type Name)

8/1

19 63

7 Place of Burial or Cremation. Holy Cross Cemetery, Malden
(City or Town)

DATE OF BURIAL August 5, 19 63

8 NAME OF FUNERAL DIRECTOR Vincent R. Rapino
ADDRESS 9 Chelsea St. East Boston, Mass.

Received and filed AUG 2 1963 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

female

white

MARRIED
WIDOWED
DIVORCED married
UNKNOWN

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Alexander Del Tergo

(Husband's name in full)

13 AGE 23

Years

Months

Days

If under 24 hours

.....HoursMinutes

14 Usual

Occupation:

Housewife

(Kind of work done during most of working life)

15 Industry

or Business:

at home

16 Social Security No.

027-30-0346

17 BIRTHPLACE (City)

(State or country)

Brookline, Mass.

18 NAME OF

FATHER

Charles J. Egan

19 BIRTHPLACE OF

FATHER (City)

Cambridge

(State or country)

Mass.

20 MAIDEN NAME

OF MOTHER

Alice Ball

21 BIRTHPLACE OF

MOTHER (City)

Brookline

(State or country)

Mass.

PARENTS

22 Informant (Address)

Alexander Del Tergo (husband)

78 Locust St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Raiph E. Sirianni (3)

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

August 2, 1963

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

QUIT OF TOWN
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 06186

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME Mary J Collins

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 66 Shore Road Drive
(Usual place of abode)

S. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, years 1 months 26 days. In place of residence, 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 11 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
April 16, 1963, to June 11, 1963

We last saw her alive on June 11, 1963, death is said to

have occurred on the date stated above, at 10:20p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gastrointestinal hemorrhage UNK Days

(b) Due To Aplastic anemia 2 Mos

(c) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS Nephrolithiasis UNK Yrs

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Charles L. Cloy, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date June 11, 1963

6 Winthrop Cemetery Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 15, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

Winthrop, Mass.

ADDRESS

Received and filed JUN 14 1963

Mary E. Manning

ASSI Registrar

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Widowed DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of James E. Collins (Husband's name in full)

12 AGE 91 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Retired Forelady (Kind of work done during most of working life)

14 Industry or Business Loose Wiles Biscuit Co.

15 Social Security No. 012-10-1443

16 BIRTHPLACE (City) Charlestown Mass (State or country)

17 NAME OF FATHER Michael B. Corcoran

18 BIRTHPLACE OF FATHER (City) Cork Ireland (State or country)

19 MAIDEN NAME OF MOTHER Catherine McCondile

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Mary O'Meara

(Address) 37 Siren St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

June 13, 1963

07767

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A TRUE COPY ATTEST:

William J. Kane

RECEIVED
City Registrar



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Burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN

(City or Town making this return)

147

06410

Registered No.

PLACE OF DEATH

Suffolk
(County)Boston
(City or Town)STANDARD
CERTIFICATE OF DEATHThe Children's Hospital Medical Center (If death occurred in a hospital or institution,
give its NAME instead of street and number)
PHYSICIAN - IMPORTANT2 FULL NAME Baby Boy Rubitsky
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No(a) Residence. No. 69 Locust St. Winthrop, Mass.
(Usual place of abode) 4 Hrs. 20 Min. (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 19, 1963
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from June 19, 1963, to June 19, 1963

I last saw him alive on June 19, 1963, death is said to have occurred on the date stated above, at 2:50 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) DIAPHRAGMATIC HERNIA 6 hrs

(b) Due To

(c) Due To

OTHER SIGNIFICANT CONDITIONS TENSION PNEUMOTHORAX 1 hr

Was autopsy performed?
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) Lucian L. Leape, M. D.
(Print or Type Name)

(Address) 300 Longwood Ave. Date June 19, 1963

6 DEATH ISRAEL - K. POK
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 21, 1963

7 NAME OF FUNERAL DIRECTOR BENJAMIN BIRNBAUM

ADDRESS 10 WASHINGTON ST. DORCH.

Received and filed JUN 25 1963

Mary E. Manning (Registrar)

A TRUE COPY ATTEST:

ASST

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN SINGLE11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) WINTHROP, MASS

17 NAME OF FATHER HARRY RUBITSKY

18 BIRTHPLACE OF FATHER (City) (State or country) BOSTON

19 MAIDEN NAME OF MOTHER IDA BODKINS

20 BIRTHPLACE OF MOTHER (City) (State or country) BOSTON

21 Informant HARRY RUBITSKY
(Address) 69 LOCUST ST. WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

17090 6/21/63
(Official Designation) (Date of Issue of Permit)

X

A TRUE COPY ATTEST:

William J. Kane.

City Registrar

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The Commonwealth of Massachusetts

148

SUFFOLK

(County)

BOSTON

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

Registered No. 08225

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

Florentino

PHYSICIAN — IMPORTANT

2 FULL NAME Antonio A. Isasi
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

(a) Residence, No. 66 Plummer Avenue st. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 27 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
June 21, 1963 to June 27, 1963
we last saw him alive on June 27, 1963 death is said to
have occurred on the date stated above, at 7:00p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Bronchopneumonia, bilateral Unk Dys

Due To (b) _____
Due To (c) _____

OTHER SIGNIFICANT CONDITIONS PULmonary Edema Unk Dys

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles L. Clay, M.D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date June 27, 1963

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 1, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JUL 5 1963

William Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Paula Elsie Hubener
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

AGE 72 years 11 months 3 days If under 24 hours
Hours Minutes

13 Usual Occupation retired machinest
(Kind of work done during most of working life)

14 Industry or Business wholesale clothing Mfg. Co.

15 Social Security No. 011-05-5105

16 BIRTHPLACE (City) Bilboa Spain
(State or country)

17 NAME OF FATHER Florentino John Isasi

18 BIRTHPLACE OF FATHER (City) Bilboa Spain
(State or country)

19 MAIDEN NAME OF MOTHER Irene Echevarria

20 BIRTHPLACE OF MOTHER (City) Bilboa Spain
(State or country)

21 Informant Richard A. Isasi

(Address) 66 Plummer Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
has been furnished with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

17214 7/1/63

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



AUG 21 1963 AM

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

METHUEN

(City or town making return)

ESSEX

(County)

Methuen

(City or Town)

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No.

No. D.O.A. Bon Secours Hospital(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Everett Mosley

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) Korean(a) Residence. No. 71 Sagamore Avenue
(Usual place of abode)St. Winthrop, Mass.
(If nonresident, give city or town and State)Length of stay: In place of death.....years.....months.....days. In place of residence 5 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 31, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)Gun Shot Wound, Cerebral5 Accident, suicide, or homicide (specify) Suicide
Date and hour of injury 8 P.M. July 31, 1963

If accidental, was injury causally related to the death?

Where did
Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?

(Specify type of place)

Manner of
Injury

(How did injury occur?)

Nature of
InjuryWhile at work? no Was autopsy performed? no6 Was disease or injury in any way related to occupation of deceased? no
If so, specify(Signed) John T. Batal M. D.
(Address) Lawrence, Mass. Date July 31, 19637 Elmwood Cemetery, Methuen, Mass.
Place of Burial or Cremation. (City or Town)DATE OF BURIAL August 2, 19638 NAME OF FUNERAL DIRECTOR Kenneth H. PollardADDRESS 233 Lawrence St., Methuen, Mass.Received and filed August 16, 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 CITIZEN OF U.S. YES ☐ NO ☐ 12 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐12a If married, widowed, or divorced
HUSBAND of Arlene Lishner
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 33 Years 11 Months 18 Days If under 24 hours
.....HoursMinutes15 Usual Occupation: Truck Mechanic
(Kind of work done during most of working life)16 Industry or Business: Garvey Trucking Co., Dorchester17 Social Security No. C.B.I.18 BIRTHPLACE (City) Hamilton, Ohio
(State or country)19 NAME OF FATHER Harrison Mosley20 BIRTHPLACE OF FATHER (City) Ohio
(State or country)21 MAIDEN NAME OF MOTHER Malverna Hatfield22 BIRTHPLACE OF MOTHER (City) Kentucky
(State or country)23 Informant (Address) Mrs. Arlene Lishner
132 Shore Drive, Winthrop, Mass.A TRUE COPY, Arlene LishnerATTEST:
(Registrar of City or Town where death occurred)DATE FILED August 7, 1963

132 Winthrop Shore Dr.

25M-3-61-930213

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AUG 1 6 1963 AM

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

Suffolk

(County)

Winthrop

(City or Town)



The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No.

150

No. Winthrop Convalescent Home

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Hannah A. Murray

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

{(Was deceased a
U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 72 Cottage Pk. Rd.

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 5 years 9 months days. In place of residence 5 years 9 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 2 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY. That I attended deceased from Feb, 1948, to Aug 2, 1963.
I last saw him alive on Aug 2, 1963, death is said to have occurred on the date stated above, at 11:30 A. M.INTERVAL
BETWEEN
ONSET AND
DEATH

2 days

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

Due To (b) ARTERIO SCLEROSIS

1044

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Louis F. Salerno, M. D.

(Address) 125 Pleasant St. Date Aug 2 1963

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 6, 1963

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
ADDRESS 325 Chelsea St. E. Boston

Received and filed AUG 5 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED10a If married, widowed, or divorced
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of John J. Murray

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: own at home

15 Social Security No. none

16 BIRTHPLACE (City) Boston Mass.
(State or country)

17 NAME OF FATHER James Quinn

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Hannah O'Brien

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Helen Powell
(Address) 72 Cottage Pk. Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siranum (S)
(Signature of Agent of Board of Health or other)Health Officer
(Official Designation)August 5, 1963
(Date of Issue of Permit)

50M-1-58-921876

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteen, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATHRegistered No. **151**

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. **Sturgis St - Bay View Nursing Home** (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Elinor L. Howard** (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)(a) Residence. No. **15 Pleasant Park Rd.** St. (Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death. **20** years. **17** months. **17** days. In place of residence. **17** years. **17** months. **17** days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH **August 4, 1963**
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from **March 1962** to **Aug 4, 1963**
I last saw her alive on **Aug 4, 1963**, death is said to have occurred on the date stated above, at **10:00 P.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebrovascular occlusion 3 days**(b) **Cerebral Arteriosclerosis 5 yrs**(c) **Generalized Arteriosclerosis 10 yrs**OTHER SIGNIFICANT CONDITIONS **None**Was autopsy performed? **clinical No**What test confirmed diagnosis? **clinical No**5 Was disease or injury in any way related to occupation of deceased? **No**If so, specify **Charles Liberman**(Signed) **CHARLES LIBERMAN M.D.**

(PRINT OR TYPE SIGNATURE)

(Address) **WINTHROP, MASS** Date **8/4/63**6 **Holyhood Cemetery Brookline**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **August 7** 19 **63**7 NAME OF FUNERAL DIRECTOR **O'Maley Funeral Home**ADDRESS **Winthrop Mass**Received and filed **AUG 6 1963** 19

(Registrar)

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word) **MARRIED****Single**

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **93** Years. Months. Days If under 24 hours Hours. Minutes13 Usual Occupation: **At Home** (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. **None**16 BIRTHPLACE (City) **Boston** (State or country) **Mass**17 NAME OF FATHER **Richard Howard**18 BIRTHPLACE OF FATHER (City) **England** (State or country)19 MAIDEN NAME OF MOTHER **Bridget Kennedy**20 BIRTHPLACE OF MOTHER (City) **Ireland** (State or country)21 Informant **Veronica Prog** (Address) **15 Pleasant Park Rd**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) **Joseph E. Sullivan** (Date of Issue of Permit) **August 6, 1963**

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATHRegistered No. **152**

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FRANCES CARSTENSEN

(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence, No. 54 ELEANOR ST. CHESEA
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death years months 5 days. In place of residence 65 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 5 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
7-30-63 to 8-5-63
I last saw her alive on 8-5-63 death is said to
have occurred on the date stated above, at 6:55 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Septicemia (Clinical)

(b) Cholecystectomy 5 days
(c) Gall stonesOTHER SIGNIFICANT CONDITIONS
HypertensionINTERVAL
BETWEEN
ONSET AND
DEATHWas autopsy performed? YES
What test confirmed diagnosis? Blood cultures being done5 Was disease or injury in any way related to occupation of deceased?
If so, specify No(Signed) John H. Crandon M. D.
(Print or Type Name)

(Address) 520 Comm Ave Boston Date Aug 5 1963

6 WOODLAWN EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUG 17 1963

7 NAME OF FUNERAL DIRECTOR Wendell W. Lyman

ADDRESS 23 Cary Ave. Chelsea

Received and filed AUG 6 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 DATE OF BIRTH APRIL 24, 1898

13 AGE 65 Years 3 Months 12 Days If under 24 hours
Hours Minutes14 Usual Occupation: HOUSEWORK
(Kind of work done during most of working life)

15 Industry or Business: OWN HOME

16 Social Security No. 0-31-34-1758

17 BIRTHPLACE (City) CHELSEA
(State or country) MASS.

18 NAME OF FATHER EDWARD CARSTENSEN

19 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS

20 MAIDEN NAME OF MOTHER MARIAN FLER

21 BIRTHPLACE OF MOTHER (City) MAINE
(State or country)22 Informant MRS. MARIAN FRANK
(Address) 5 COURT RD. WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Carph E. Scrimm (B)
(Signature of Agent of Board of Health or other)
August 6, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



AUG 6 1963 PM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

Suffolk
(County)

Winthrop
(City or Town)

STANDARD CERTIFICATE OF DEATH

Registered No. **153**

No. **Bay View Nursing Home**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME **Roach, Violet Estelle**

{(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

(a) Residence. No. **243 Winthrop Street**
(Usual place of abode)

St. **41 Washington Ave.**
(If nonresident, give city or town and State)

Length of stay: In place of death. **8** years **2** months **2** days. In place of residence **40** years **0** months **0** days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH **August 11 1963**
(Month) (Day) (Year)

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED **Widowed**
WIDOWED
or DIVORCED

4 I HEREBY CERTIFY That I attended deceased from
Nov. 1952 to **August 11, 1963**
I last saw her alive on **Aug. 10, 1963**, death is said to
have occurred on the date stated above, at **11:30 A.M.**

10a If married, widowed, or divorced
HUSBAND of

(or) WIFE of **Edmund Thompson Roach**
(Give maiden name of wife in full)
(Husband's name in full)

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebrovascular Occlusion** **3 yrs**

Due To **Cerebro arteriosclerosis**

Due To

OTHER
SIGNIFICANT
CONDITIONS

None

Was autopsy performed?

What test confirmed diagnosis? **Clinical**

5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify

(Signed) **Charles Liberman, M.D.**
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) **Winthrop, Mass.** Date **8/11/63**

6 **Winthrop Cemetery, Winthrop, Mass.**
Place of Burial or Cremation

DATE OF BURIAL **August 13, 1963**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**
ADDRESS **174 Winthrop St. Winthrop, Mass.**

Received and filed **August 13, 1963**

(Registrar)

11 IF STILLBORN, enter that fact here.

12 AGE **71** Years **0** Months **27** Days
If under 24 hours
Hours Minutes

13 Usual Occupation: **housework**
(Kind of work done during most of working life)

14 Industry or Business: **own home**

15 Social Security No. **none**

16 BIRTHPLACE (City) **Erving**
(State or country) **Massachusetts**

17 NAME OF FATHER **Charles F. Noyes**

18 BIRTHPLACE OF FATHER (City) **Jefferson**
(State or country) **Maine**

19 MAIDEN NAME OF MOTHER **Josephine Clary**

20 BIRTHPLACE OF MOTHER (City) **Jefferson**
(State or country) **Maine**

Informant **Ralph E. Roach**
(Address) **Alstead, New Hampshire**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) **Severthoff** (Date of Issue of Permit) **Aug 13, 1963**

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

AUG 11 3 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 154

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Amy Gertrude Hearn
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)(a) Residence, No. 265 Newbury
(Usual place of abode)St. Boston
(If nonresident, give city or town and State)

Length of stay: In place of death 6 years 6 months 35 days. In place of residence 35 years 6 months 35 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 12, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 26, 1963, to August 12, 1963
I last saw her alive on August 12, 1963, death is said to
have occurred on the date stated above, at 5:10 P.M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bilateral Bronchopneumonia 1 wk.

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSAtherosclerotic Ht. 3 yrs.
DISEASEWas autopsy performed? No
What test confirmed diagnosis? Clinical & Lab.5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signature) M. Traumstein Jr. M. D.
M. TRAUMSTEIN JR. M.D.
(Print or Type Name)(Address) 73 BARTLETT ST. WINTHROP
SPRINGCLIFF CEM. HARTSDALE, N.Y.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 12, 1963

7 NAME OF FUNERAL DIRECTOR J. SWATERMAN & SONS

ADDRESS Boston

Received and filed August 13, 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F. 9 COLOR W. 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 83 Years 4 Months 23 Days If under 24 hours
Hours Minutes13 Usual Occupation Nurse (Ret.)
(Kind of work done during most working life)

14 Industry or Business Boston State Hosp

15 Social Security No. No

16 BIRTHPLACE (City) ENGLAND
(State or country)

17 NAME OF FATHER Reuben Hearn

18 BIRTHPLACE OF FATHER (City) ENGLAND
(State or country)

19 MAIDEN NAME OF MOTHER Caroline J. Elkins

20 BIRTHPLACE OF MOTHER (City) ENGLAND
(State or country)21 Informant William Hearn
(Address) Clementsport, N. C. SectionI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:(Signature of Agent of Board of Health or other)
Health Officer Aug. 13, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



AUG 13 1963 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 155

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 67 Marshall

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Sarah Ciccarelli (Marino)
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran, no
if so specify WAR)(a) Residence. No. 67 Marshall St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 31 years.....months.....days. In place of residence 31 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 14, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw h..... alive on....., 19....., death is said to
have occurred on the date stated above, at 1:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
to natural causes,(b) Due to
(c) probably acute coronary
occlusion on basis
of history.OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? Charles Liberman, M.D.
What test confirmed diagnosis? Winthrop Board of Health5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles Liberman, M.D.

Charles Liberman, M.D.
(Print or Type Name)

(Address) 8/12 1963

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 17, 1963

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
147 Winthrop St., Winthrop

ADDRESS

Received and filed AUG 16 1963 19

INTERVAL
BETWEEN
ONSET AND
DEATH

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)
(or) WIFE of Richard Ciccarelli
(Husband's name in full)12 AGE 70 11 13
YEARS MONTHS DAYS If under 24 hours
.....Hours.....Minutes13 Usual Occupation: housewife
(Kind of work done during most working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Flaminio Marino

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Maria Grazia Savino

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Robert Ciccarelli
(Address) 69 Marshall St., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Eugene E. Liberman
(Signature of Agent of Board of Health or other)Health Officer Aug 16, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

(Registrar)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



AUG 16 1963 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 156

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charlotte (Walsh) Tobin
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 18 Haviland
(Usual place of abode)St. Boston, Mass
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months..6..days. In place of residence..50..years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 15 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Aug 9, 1963, to Aug 15, 1963
I last saw her alive on Aug 15, 1963, death is said to
have occurred on the date stated above, at 2:58 P.M.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease
Due To

(b) Arteriosclerosis

(c) Generalized

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Joseph G. Greer, M. D.

Joseph G. GREER, M. D.
(Print or Type Name)

(Address) 194 Washington St. Date Aug 15 1963

6 Ridgelawn Cemetery, Watertown
Place of Burial (City or Town)

DATE OF BURIAL August 17, 1963

NAME OF FUNERAL DIRECTOR Frank A. McDonald
ADDRESS 461 Commonwealth Ave.

Received and filed AUG 16 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of JOHN TOBIN
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 31 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: AT HOME
(Kind of work done during most working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) FRANKLIN, MASS.
(State or country)

17 NAME OF FATHER Walsh

18 BIRTHPLACE OF FATHER (City) C.B.L.
(State or country)

19 MAIDEN NAME OF MOTHER C.B.L.

20 BIRTHPLACE OF MOTHER (City) C.B.L.
(State or country)21 Informant Miss B. CRANE
(Address) (Granddaughter) 1726 Beacon St.,
BrooklineI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:(Signature of Agent of Board of Health or other)
Health Officer August 16, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



AUG 16 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 157

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME **EVERETT K. LOW**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. **200 BARTLETT RD** St. (City or town and State)

Length of stay: In place of death **30** years.....months.....days. In place of residence **30** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **August 17 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Jan 3 1960 to **August 17 1963**
I last saw him alive on **August 17 1963**, death is said to
have occurred on the date stated above, at **2:30 P.M.**

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **CORONARY HEART DISEASE**

142

Due To **MYOCARDIAL INFARCTION**

148

Due To
(c)

OTHER SIGNIFICANT CONDITIONS **AMYLOIDOSIS OF LARGE BOWEL**

2 MOS.

Was autopsy performed? **no**
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify

(Signature) **Louise F. Salerno**, M. D.
LOUISE SALERNO
(Print or Type Name)

(Address) **175 Pleasant St. WINTHROP** Date **Aug 18 1963**

6 **WOODLAWN** **EVERETT**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **AUG 20 1963**

7 NAME OF FUNERAL DIRECTOR **MAURICE W. KIRBY**

ADDRESS **WINTHROP**

Received and filed **AUG 20 1963**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN **MARRIED**

11 If married, widowed, or divorced
HUSBAND of **VIOLET NEVINS**
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE **77** Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: **BANNER (RETIRED)**
(Kind of work done during most of working life)

14 Industry or Business: **BANK**

15 Social Security No. **012-16-5819**

16 BIRTHPLACE (City) **EAST BOSTON**
(State or country) **MASS**

17 NAME OF FATHER **ALBERT E LOW**

18 BIRTHPLACE OF FATHER (City) **ESSEX**
(State or country) **MASS**

19 MAIDEN NAME OF MOTHER **EMMA MENISON**

20 BIRTHPLACE OF MOTHER (City) **BOSTON**
(State or country) **MASS**

21 Informant **MRS VIOLET LOW**

(Address) **200 BARTLETT RD WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan
(Signature of Agent of Board of Health or other)

Health Officer **August 20 1963**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. 158

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No.

Winthrop Community Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Baby Girl Gerardi
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran, no
if so specify WAR)(a) Residence, No. 180 Waldemar Avenue
(Usual place of abode)St. East Boston
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 19, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from 19 AUGUST, 1963, to....., 19.....
I last saw her alive on 19 AUGUST, 1963, death is said to
have occurred on the date stated above, at 1:42 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PREMATURITYINTERVAL
BETWEEN
ONSET AND
DEATH
3hrDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) Robert Bornstein, M. D.

(Print or Type Name)

(Address) 150 PLEASANT ST Date 19 AUGUST 1963
WINTHROP6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)DATE OF BURIAL August 21, 19637 NAME OF FUNERAL DIRECTOR Vincent R. RapinoADDRESS 9 Chelsea Street, East Boston, Mass.Received and filed AUG 20 1963, 19.....

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN single

11 If married, widowed, or divorced

HUSBAND of
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE.....Years.....Months.....Days If under 24 hours
3.....Hours.....Minutes13 Usual Occupation: none
(Kind of work done during most working life)14 Industry or Business: ****15 Social Security No. none16 BIRTHPLACE (City) Winthrop, Mass.
(State or country)17 NAME OF FATHER John Gerardi18 BIRTHPLACE OF FATHER (City) Italy
(State or country)19 MAIDEN NAME OF MOTHER Veronica Rapino20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.21 Informant John Gerardi (father)
(Address) 180 Waldemar Ave., East BostonI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Siranni (S)
(Signature of Agent of Board of Health or other)Health Officer
(Official Designation)August 20, 1963
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

AUG 20 1963 TM

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 8 Siren Street

STANDARD CERTIFICATE OF DEATH

Registered No. 159

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

2 FULL NAME Helen Beattie
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 8 Siren Street
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence. 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 20, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from June 1946, to AUG 20 1963
I last saw her alive on AUG 16 1963, death is said to have occurred on the date stated above, at 6:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY OCC.

Due To (b) ARTERIO-SCLEROTIC AND

Due To (c) HYPERTHYROID HEART

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron H. King, M. D.

(Address) 222 Pleasant St. Date AUG 21 1963

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 23, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
Winthrop Mass.

ADDRESS

Received and filed AUG 22 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Charles Beattie (Husband's name in full)

12 AGE 59 Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation Switchboard Operator (Kind of work done during most working life)

14 Industry or Business Telephone

15 Social Security No. 16 BIRTHPLACE (City) Somerville (State or country) Mass

17 NAME OF FATHER Benjamin Robbins

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass

19 MAIDEN NAME OF MOTHER Elizabeth Runey

20 BIRTHPLACE OF MOTHER (City) Somerville (State or country) Mass

21 Informant Charles Beattie (Address) 8 Siren St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Scramm (Signature of Agent of Board of Health or other) Health Officer August 22 1963 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



AUG 22 1963 PM

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 160

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, no
if so specify WAR)2 FULL NAME Angelina (Diorio) Ceruolo
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 49 Bayswater St.
(Usual place of abode)St. East Boston, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 3 days. In place of residence, 25 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 20 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
7/26, 1963, to 8-20-63I last saw her alive on 8-20-63, death is said to
have occurred on the date stated above, at 9 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

INTERVAL
BETWEEN
ONSET AND
DEATH12 hr
years

Due To (b) HYPERTENSION

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Pasquale Costanza, M. D.

(Address) 238 Maverick St., East Boston
(Print or Type Name) Pasquale Costanza, M.D.

Date 8/21 1963

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 24, 1963

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston

Received and filed AUG 22 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Divorced
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Nicholas Ceruolo
(Husband's name in full)12 AGE 56 Years, Months, Days If under 24 hours
Hours, Minutes13 Usual Occupation Salesgirl
(Kind of work done during most working life)

14 Industry or Business J. W. Woolworth Co.

15 Social Security No. unknown 025-12-7974

16 BIRTHPLACE (City) Chelsea, Mass.
(State or country)

17 NAME OF FATHER Domenic DiDrio

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Susie Tontodonato

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Susie DiDrio (mother)
(Address) 49 Bayswater St., East Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Linnane (31)
(Signature of Agent of Board of Health or other)Health Officer August 22 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. **161**

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)No. **235 WASHINGTON AVE**

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME **GEORGE A HUNTER**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, **NO**
if so specify WAR)

(a) Residence. No. **235 WASHINGTON AVE** St. **WINTHROP**
(Usual place of abode) (City or town and State)

Length of stay: In place of death **4** years.....months.....days. In place of residence **4** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Aug 26, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw him alive on....., 19....., death is said to
have occurred on the date stated above, at **9:15 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Death presumably due**
(b) **to natural causes, probably**
(c) **acute coronary occlusion on**

OTHER SIGNIFICANT CONDITIONS **basis of history.**
Winthrop Board of Health

Was autopsy performed? **Charles Liberman M.D.**
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? **NO**
If so, specify

(Signature) **Charles Liberman M.D.**
CHARLES LIBERMAN
(Print or Type Name)

(Address) **WINTHROP, MASS.** Date **8/27/1963**

6 **WINTHROP** **WINTHROP**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **AUG 29** 19**63**

7 NAME OF FUNERAL DIRECTOR **MAURICE W. KIRBY**

ADDRESS **WINTHROP, MASS.**

Received and filed **AUG 29 1963** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN **MARRIED**

11 If married, widowed, or divorced
HUSBAND of **MARY A. TRAINOR**
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE **66** Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: **CLERK**
(Kind of work done during most of working life)

14 Industry or Business: **OFFICE**

15 Social Security No. **012-05-3079**

16 BIRTHPLACE (City) **WINSTON**
(State or country) **N.B. CANADA**

17 NAME OF FATHER **JOHN HUNTER**

18 BIRTHPLACE OF FATHER (City) **WINSTON**
(State or country) **WINSTON N.B. CANADA**

19 MAIDEN NAME OF MOTHER **WILLIAMS**

20 BIRTHPLACE OF MOTHER (City) **WINSTON**
(State or country) **N.B. CANADA**

21 Informant **MRS MARY HUNTER**
(Address) **235 WASHINGTON AVE WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph S. Liberman
(Signature of Agent of Board of Health or other)
Health Officer **August 29, 1963**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED



RULES OF PRACTICE

AUG 29 1963 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 162

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. MAYFLOWER NURSING HOME 39 GROVER ST. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPHINE L GRADY (O'DONNELL)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, if so specify WAR) NO(a) Residence No. 40 WASHINGTON AVE
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death 30 years months 30 days. In place of residence 25 years months 25 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 27 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from May 1962 to Aug 27 1963.
I last saw her alive on Aug 25 1963 death is said to have occurred on the date stated above, at 1:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial heart disease

(b) Chronic valvular heart disease

(c) Atherosclerosis gen

INTERVAL
BETWEEN
ONSET AND
DEATH

yo

yo

yo

OTHER SIGNIFICANT CONDITIONS Abdominal Aorta aneurysm
Ca of colon

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify(Signature) Joseph GREGORIE, M.D.
(Print or Type Name)

(Address) 194 Washington Ave Date 8/29 1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUG 30 1963

7 NAME OF FUNERAL DIRECTOR MARRICE W MIRBY

ADDRESS WINTHROP, MASS

Received and filed AUG 29 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED

11 If married, widowed, or divorced HUSBAND of

(Give maiden name of wife in full)
(or) WIFE of EDMUND C GRADY
(Husband's name in full)

12 AGE 76 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation HOME MAIDEN
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. 017-26-4604

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

17 NAME OF FATHER JOHN J O'DONNELL

18 BIRTHPLACE OF FATHER (City) EAST BOSTON
(State or country)

19 MAIDEN NAME OF MOTHER MARGARET PETERS

20 BIRTHPLACE OF MOTHER (City) P.E.I.
(State or country)

21 Informant CHARLES J O'DONNELL

(Address) 146 MT VERNON RD MELROSE

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer August 29 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

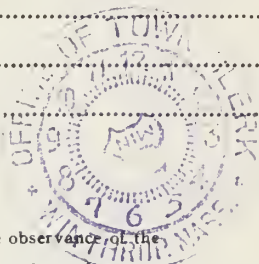
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)



Winthrop

(City or Town)

No. 10 Winthrop Community

STANDARD CERTIFICATE OF DEATH

Registered No. 163

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME Fortunato Musto (Finzio)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 9 Johnson Ave,
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 29 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1963, to Aug 29, 1963

I last saw him alive on Aug 29, 1963, death is said to have occurred on the date stated above, at 11:00 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

30 min

(b) Due To

arteriosclerosis

40

(c) Due To

gen.

OTHER SIGNIFICANT CONDITIONS

none

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Joseph J. Grogan, M. D.

(Print or Type Name) Joseph J. Grogan

(Address) 1940 Winthrop St, Date 8/30 1963

Winthrop Winthrop Mass

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 3 1963

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St, Winthrop

Received and filed SEP 3 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Joseph Musto (Husband's name in full)

12 AGE 82 Years 10 Months 5 Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: At Home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Italy

17 NAME OF FATHER Unknown Finzio

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Unknown

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant (Address) Mrs Albert Mangini 96 Plummer Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph B. Giovanni (p)
(Signature of Agent of Board of Health or other)
Health Officer 9/1/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease, unrelated to any form of injury, have died without recent medical attendance, or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 164

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 129 Strandway

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT2 FULL NAME Cornelius J. Sullivan
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, W.W. 2
if so specify WAR)(a) Residence, No. 129 Strandway
(Usual place of abode)St. Winthrop
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence. 18 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 30, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased, from
4/27/1959, to Aug 30, 1963
I last saw him alive on Aug 30, 1963 death is said to
have occurred on the date stated above, at 3:24 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

(b) arteriosclerosis

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Joseph J. Greer, M. D.

(Print or Type Name)

(Address) 194 Wash. St. W. Date 8/30/63

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 3, 1963

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St. E. Boston

Received and filed SEP 3 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Married
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Edith G. Gillogly
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE 70 Years..... Months..... Days If under 24 hours
Hours..... Minutes13 Usual Occupation: Taxi OWNER-Operator
(Kind of work done during most of working life)

14 Industry or Business: Owner Taxi Business

15 Social Security No. 029-22-2942

16 BIRTHPLACE (City) Cambridge, Mass.
(State or country)

17 NAME OF FATHER Florence J. Sullivan

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary T. Flanagan

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Mrs. Edith G. Sullivan

(Address) 129 Strandway Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Serrano (Signature of Agent of Board of Health or other)

Health Officer 8/31/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

Aug 27 1942

DATE OF DISCHARGE.....

Oct 21 1943

RANK, RATING

Chief

ORGANIZATION AND OUTFIT

US Coast Guard Reserve

SERVICE NUMBER.....

3005-529

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths apparently due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OUT - OF - TOWN

R-301

PLACE OF DEATH

Suffolk
(County)
Boston
(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 07107

Veterans Administration Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)
PHYSICIAN - IMPORTANT

2 FULL NAME John S. ROBERTS
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW I

(a) Residence. No. 59 Crest Avenue x. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death... years... months... -1 days. In place of residence 30 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 9, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from July 9, 1963, to July 9, 1963

death is said to have occurred on the date stated above, at 7:45 P.m.

INTERVAL BETWEEN ONSET AND DEATH hrs.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Pulmonary edema and congestion

Due To (b) Aortic stenosis and mitral insufficiency, rheumatic yrs.

Due To (c) Left ventricular hypertrophy yrs.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Michael J. Baccari, M. D.
(Print or Type Name) Michael J. Baccari
(Address) VAH Boston, Mass. July 10 1963

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 12 1963

7 NAME OF FUNERAL DIRECTOR Maurice Kirby

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed JUL 15 1963
William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Dorothy O'Leary
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 62 Years 2 Month 10 Days If under 24 hours Hours Minutes

13 Usual Occupation Shipfitter (Retired)
(Kind of work done during most of working life)

14 Industry or Business SHIP YARD

15 Social Security No.

16 BIRTHPLACE (City) Chelsea Mass.
(State or country)

17 NAME OF FATHER Charles Roberts

18 BIRTHPLACE OF FATHER (City) UNKNOWN
(State or country)

19 MAIDEN NAME OF MOTHER SARAH ADDISON

20 BIRTHPLACE OF MOTHER (City) UNKNOWN
(State or country)

21 Informant Veterans Administration Records
(Address) 150 So. Hunt. Ave., Boston, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) B17380
(Official Designation) 7-11-63
(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



SEP 23 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN

(City or Town making this return)

Suffolk

(County)

Boston

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Veterans Administration Hospital

Registered No. 7411

No.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

Frederick Anders ANDERSON

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a

WW 1

U. S. War Veteran,
if so specify WAR)

1069 Shirley

Winthrop, Mass

(a) Residence. No.

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 17 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 7, 1963, to July 17, 1963

Death is said to
have occurred on the date stated above, at 4:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Metastatic malignant melanoma

(a) Due To Metastasis to heart, brain, liver
(b) lungs adrenals
2 mos

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Michael J. Baccari, M.D.

(Print or Type Name)

(Address) VAH Boston, Mass. Date July 17, 63

6 Woodlawn Cem. Everett, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL 7-20-63

7 NAME OF FUNERAL DIRECTOR Brown F.H.

ADDRESS 11 Pembroke St., Medford, Mass.

Received and filed
William Kane

JUL 24 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Lillian
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE 70 0 Months 7 Days If under 24 hours
Hours Minutes

13 Usual Occupation Plumber, retired
(Kind of work done during most of working life)

14 Industry or Business.....

15 Social Security No. 013-22-7527

16 BIRTHPLACE (City). Nova Scotia
(State or country)

17 NAME OF FATHER Lars

18 BIRTHPLACE OF FATHER (City). Norway
(State or country)

19 MAIDEN NAME OF MOTHER Henrietta Von Schoppe

20 BIRTHPLACE OF MOTHER (City). Nova Scotia
(State or country)

21 Informant V.A. Hospital Records

(Address) 150 S. Huntington Ave.
Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Signature of Agent of Board of Health or other
1/24/63 7/19/63

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



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The Commonwealth of Massachusetts

167

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN

(City or Town making this return)

Suffolk

(County)

Boston

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No. 07593

Veterans Administration Hospital
No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, WW I
if so specify WAR)2 FULL NAME George A. WOOD
(If deceased is a married, widowed or divorced woman, give also maiden name.)

12 Sewall Ave.

(a) Residence. No.
(Usual place of abode)

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months 8 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 24 1963
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from
July 16 1963 to July 24 1963

death is said to

have occurred on the date stated above, at 2:00P.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Recent infarction Rt. cerebellum 4 days

(b) Due To Septal myocardial infarction Wk
with mural thrombosis

(c) Due To Rt. Chronic pyelonephritis yrs

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Kevin D. O'Brien M.D., M. D.

(Print or Type Name)

(Address) VAH Boston, Mass. Date July 25 1963

6 West Lawn Cem. Lowell, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 27 1963

7 NAME OF FUNERAL DIRECTOR Reynolds F.H.

ADDRESS 180 Winthrop St., Winthrop, Mass.

Received and filed

JUL 31 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR white 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Maude Phillips

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 67 Years 11 Months 28 Days 11 under 24 hours
Hours Minutes13 Usual Occupation Ret. Grill Man
(Kind of work done during most of working life)

14 Industry or Business 023 10 3896

15 Social Security No. 16 BIRTHPLACE (City) Swampscott
(State or country) Mass.

17 NAME OF FATHER George

18 BIRTHPLACE OF FATHER (City) France
(State or country)

19 MAIDEN NAME OF MOTHER Whorf

20 BIRTHPLACE OF MOTHER (City) Massachusetts
(State or country)21 Informant V.A. Hospital Records 150 S.
Huntington Ave., Boston, Mass.
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

18835 7/26/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane. RECEIVED

City Registrar



OCT 3 1963 PM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town in which the deceased resided at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

PLACE OF DEATH

Essex

(County)

Lynn

(City or Town)



The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Lynn

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 168

No. Lynn Hospital

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME Claire Caruso (Ostman)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR. -----)(a) Residence, No. 100 Marshall
(Usual place of abode)

Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....1 days. In place of residence.....32 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 14, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
8/13 1963 8/14 1963
I last saw him alive on 8/14 1963 death is said to
have occurred on the date stated above, at 11:40P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac failure

INTERVAL
BETWEEN
ONSET AND
DEATH
24 hrs

Due To Hydrocephalus

(b)

mos.

Due To Brain tumor

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? x-ray

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify(Signed) Sidney Paly M. D.
281 Humphrey St.
(Address) Swampscott Date 8/16 19636 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 17, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed XXXXXXIXX 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Nicholas W. Caruso
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 32 Years. - Months. - Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: Reg. Nurse
(Kind of work done during most of working life)

14 Industry or Business: Nursing

15 Social Security No. 029-24-8220

16 BIRTHPLACE (City) Winthrop,
(State or country) Mass.

17 NAME OF FATHER George H. Ostman

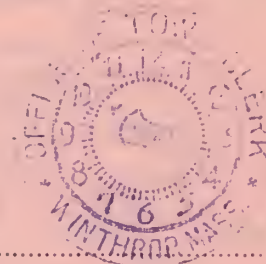
18 BIRTHPLACE OF FATHER (City) Winthrop,
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Bridie Feeney

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Bridie Ostman
(Address) 100 Marshall St., WinthropA TRUE COPY
ATTEST: Albert L. Silym
(Registrar of City or Town where death occurred)

DATE FILED August 19, 1963

T V A ✓



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)

Mount Auburn Hospital

No.

 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Cambridge

(City or Town making this return)

COPY OF

CERTIFICATE OF DEATH

Registered No. 1208

 (If death occurred in a hospital or institution,
 St. give its NAME instead of street and number)

 2 FULL NAME Ralph James Paone
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

 (Was deceased a
 U. S. War Veteran, no
 if so specify WAR,

38 Paine St.

(a) Residence. No.

(Usual place of abode)

St.

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death, 22 years, 21 months, 21 days. In place of residence, 22 years, 21 months, 21 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 16, 1963

(Month)

(Day)

(Year)

 4 I HEREBY CERTIFY That I attended deceased from
 July 1963 to Aug. 16, 1963
 I last saw him alive on Aug. 16, 1963, death is said to
 have occurred on the date stated above, at 10:30a.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Peritonitis

Due To Ca. Stomach

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSINTERVAL
BETWEEN
ONSET AND
DEATH

2wks.

6mos.

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

 5 Was disease or injury in any way related to occupation of deceased? no
 If so, specify

(Signed) Albert S. Murphy

M. D.

(Address) Boston, Mass. Date 8-16-63

6 Winthrop Cem. Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 19 1963

7 NAME OF FUNERAL DIRECTOR Maurice A. Kirby

ADDRESS 210 Winthrop St. Winthrop

Received and filed SEP 11 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Married

11 If married, widowed or divorced
HUSBAND of Louisa Ventri

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 57 Years, Months, Days

If under 24 hours

Hours, Minutes

13 Usual
Occupation:

Salesman

(Kind of work done during most working life)

14 Industry
or Business:

Sunshine Biscuit

012-10-1638

15 Social Security No.

Revere

16 BIRTHPLACE (City)
(State or country)

Mass.

17 NAME OF
FATHER

Cosmo Paone

18 BIRTHPLACE OF
FATHER (City)
(State or country)

Italy

19 MAIDEN NAME
OF MOTHER

(c.n.b.l.) Albano

20 BIRTHPLACE OF
MOTHER (City)
(State or country)

Italy

21 Informant
(Address)

Mrs. Ralph Paone

38 Paine St. Winthrop

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

Aug. 19, 1963

T V K

 Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town
 at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased
 resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

001

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk
(County)

Winthrop
(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No. 170

No. 25 Sargent Street, Winthrop

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Albertine Cecelia (Bohm) Drake
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 25 Sargent Street
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 47 years.....months.....days. In place of residence 47 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 1 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Aug 31 1962 to Sept 1 1963
I last saw the alive on Aug 31 1963, death is said to
have occurred on the date stated above, at 5:05 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular hemorrhage 6 hr

Due To (b) Arteriosclerosis gen. yrs.

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph E. S. same M. D.

(Print or Type Name)

(Address) 1844 Washington Ave Date 9/12 1963

6 Winthrop, Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 3, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed SEP 3 1963 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN
Widowed

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Millard Illewellyn Drake
(Husband's name in full)

12 AGE 82 2 Months 21 Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: Housework
(Kind of work done during most working life)

14 Industry or Business Own At Home

15 Social Security No. 022-10-6488

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

17 NAME OF FATHER Leon Bohm

18 BIRTHPLACE OF FATHER (City) Germany (Europe)
(State or country)

19 MAIDEN NAME OF MOTHER Louise A. Pavier

20 BIRTHPLACE OF MOTHER (City) Washington, D. C.
(State or country)

21 Informant Millard L. Drake (son)
(Address) 415 North Clay Street
Hinsdale, Illinois

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Suranme (B)
(Signature of Agent of Board of Health or other)
Health Officer Sept 3, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)

No. Holy Ghost Hospital

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Cambridge

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 1293

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)2 FULL NAME Barbara Bowman
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, no
if so specify WAR,

8 Paine Street

Winthrop, Mass.

(a) Residence, No. St. (If nonresident, give city or town and State)

Length of stay: In place of death 5 years 6 months 16 days. In place of residence 35 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 4, 1963

(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Feb. 19, 1958 to Sept. 4, 1963I last saw him alive on Sept. 3, 1963 death is said to
have occurred on the date stated above, at 1:50a.m.INTERVAL
BETWEEN
ONSET AND
DEATHDEATH WAS CAUSED BY: IMMEDIATE CAUSE
Acute diffuse peritonitis
(ruptured gallbladder)

(a) Due To Pulmonary congestion & edema

(b) Due To Old cerebral infarcts -
(c) extensively involving the left
parietal, temporal and
occipital lobes.OTHER
SIGNIFICANT
CONDITIONS art. scl. & Hypertensive heart
disease

Was autopsy performed? yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) John F. Lee

M. D.

(Address) Holy Ghost Hosp. 0-4 19 63

6 Winthrop Cem. Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 7, 19 63

7 NAME OF FUNERAL DIRECTOR Anthony J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed OCT 4 1963 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED Single
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 88 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Stitcher - Retired
(Kind of work done during most working life)

14 Industry or Business: Shoe

15 Social Security No. none
16 BIRTHPLACE (City) Montreal
(State or country) Canada

17 NAME OF FATHER Peter P. Bowman

18 BIRTHPLACE OF FATHER (City) Quebec
(State or country) Canada

19 MAIDEN NAME OF MOTHER Delia B. Robinson

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Ellen F. Bowman
(Address) 8 Paine St. Winthrop

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Sept. 5, 19 63

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED



OCT 4 1963 AM

PLACE OF DEATH

SUFFOLK

(County)
WINTHROP

(City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

Registered No. 172

16 Court Road, Winthrop

No. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MILDRED HOWE
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)(a) Residence. No. 16 Court Road, Winthrop St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death 22 years.....months.....days. In place of residence 55 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 7, 1963
(Month) (Day) (Year)
4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Arteriosclerotic heart disease.
(77).5 Accident, suicide, or homicide (specify)
Date and hour of injury19.....
IF ACCIDENTAL, was injury causally related to the death?
Where did injury occur?
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place?
(Specify type of place)
Manner of injury
(How did injury occur?)
Nature of injury
While at work? Was autopsy performed? No6 Was disease or injury in any way related to occupation of deceased?
(Signed) Michael A. Luongo, M.D.
Boston (Print or Type Name)
(Address) Boston Date 9/7 637 WINTHROP WINTHROP
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL SEPT 10 19638 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed SEP 9 1963 19

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX FEMALE 10 COLOR WHITE 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED
12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of CHARLES HOWE (Husband's name in full)
13 AGE 45 Years Months Days If under 24 hours Hours Minutes
14 Usual Occupation HOME MAKER. (Kind of work done during most of working life)
15 Industry or Business HOME
16 Social Security No. NINE
17 BIRTHPLACE (City) EAST BOSTON (State or country) MASS
18 NAME OF FATHER DAVID J MAHONY
19 BIRTHPLACE OF FATHER (City) RANDOLPH (State or country) MASS
20 MAIDEN NAME OF MOTHER ANNA BOYCE
21 BIRTHPLACE OF MOTHER (City) CAMBRIDGE (State or country) MASS
22 Informant MPS NANCY EVANS (Address) 216 COURT RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Soranni (a) (Signature of Agent of Board of Health or other)
Dorothy Jones Sept 9 1963 (Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

SEP - 9 1953 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

M R-301A

-THIS IS A
NENT RECORD.
se only

APPROVED

ink or black
riter ribbon.

STRUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

not enter
than one
e for each
(b) and (c)

does not mean
le of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
o the terminal
condition given

Chapter 137,
1954, requires
ans to print or
e cause or
of death on
certificates.

HAP. 46, §§ 9 &

HAP. 114 §§ 45,

HAP. 38 § 6.)

10-58-923886

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSP.

No.

2 FULL NAME

ANNA RUSSO (NEE MAZZARELLA)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

57 WINTHROP PARKWAY

(a) Residence. No.

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death years months 20 days. In place of residence 9 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

Sept. 8 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from

June, 1961, to Sept. 8, 1963

I last saw her alive on Sept. 7, 1963, death is said to have occurred on the date stated above, at 11:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebro-vascular hemorrhage

Due To (b) arteriosclerosis gen

Due To (c) Diabetes mellitus

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed)

(Address)

6 HOLY CROSS CEMETERY, MALDEN, MASS.

Place of Burial or Cremation

DATE OF BURIAL

SEPT. 11, 1963

7 NAME OF FUNERAL DIRECTOR

LAWRENCE BRUNO

ADDRESS

291 REVERE STREET, REVERE, MASS.

Received and filed

SEP 9 1963

(Registrar)

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

Registered No.

173

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

if so specify WAR)

NO

REVERE

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

FEMALE

9 COLOR

WHITE

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

MARRIED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

PETER RUSSO

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 63

Years

7

Months

14

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation:

HOUSEWIFE

(Kind of work done during most of working life)

14 Industry

or Business:

AT HOME

15 Social Security No.

024 05 5592

16 BIRTHPLACE (City)

(State or country)

ITALY

17 NAME OF FATHER

JOSEPH MAZZARELLA

PARENTS

18 BIRTHPLACE OF

FATHER (City)

(State or country)

ITALY

19 MAIDEN NAME

LAURA CAPUCCI

OF MOTHER

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

ITALY

21

Informant

(Address)

PETER RUSSO (HUSBAND)

57 WINTHROP PARKWAY, REVERE, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Sironi

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

Sept. 9, 1963

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **174**

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

No. **114 LINCOLN ST**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME **MARGARET A (TAYLOR) BURNS**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a
U. S. War Veteran,
(if so specify WAR) **NO**

(a) Residence. No. **114 LINCOLN ST**
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death **11** years.....months.....days. In place of residence **11** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Sept. 10, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw him.....alive on....., 19....., death is said to
have occurred on the date stated above, at **8:00 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Death presumably due**

Due To **to natural causes.**

(b) **Winthrop Board of Health.**
(c) **Charles Liberman, M.D.**

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) **Charles Liberman** M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) **WINTHROP, MASS.** Date **9/21** 19 **63**

6 **HOLY CROSS** **WINTHROP**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **SEPT 13** 19 **63**

7 NAME OF FUNERAL DIRECTOR **MAURICE W KIRBY**
ADDRESS **WINTHROP**

Received and filed **SEP 13 1963** 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **FEMALE** 9 COLOR **WHITE** 10 SINGLE (write the word)
MARRIED
WIDOWED
or **DIVORCED** **WIDOWED**

10a If married, widowed, or divorced
HUSBAND of **EDWARD B BURNS**
(Give maiden name of wife in full)
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **87** Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: **HOME MAKER**
(Kind of work done during most of working life)

14 Industry or Business: **HOME**

15 Social Security No.

16 BIRTHPLACE (City) **EAST BOSTON**
(State or country) **MASS**

17 NAME OF FATHER **JOHN TAYLOR**

18 BIRTHPLACE OF FATHER (City) **IRELAND**
(State or country)

19 MAIDEN NAME OF MOTHER **MARY J BROGAN**

20 BIRTHPLACE OF MOTHER (City) **ENGLAND**
(State or country)

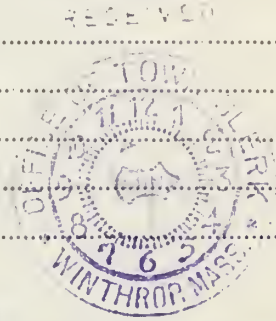
21 Informant (Address) **MRS CLARE M SCOBORIA**
114 LINCOLN ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E Liberman
(Signature of Agent of Board of Health or other)

Death officer **Sept 13 1963**
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
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for each
b) and (c)es not mean
of dying,
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ic. It means
e, or compli-
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cause (a),
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the terminal
ndition givenChapter 137,
1954, requires
s to print or
cause or
of death on
ificates, and
48, Acts of
quires Physi-
print or type
er signature.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Mount Nursing Home Inc.

's Convalescent

CERTIFICATE OF DEATH

STANDARD

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 175

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Rose Green Span ROSE GREENSPAN

(If deceased is a married, widowed or divorced woman, give also maiden name.) (If so specify WAR)

(a) Residence. No. 227 Broadway
(Usual place of abode)St. Chelsea, Ma ss.
(If nonresident, give city or town and State)

Length of stay: In place of death 2 years 5 months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 13, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
April 10th, 1963, to Sept 13th, 1963I last saw her alive on Sept 13, 1963, death is said to
have occurred on the date stated above, at 4 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Cardiac Decon-
sation & Pulmonary Edema 5 hrsDue To Ch. Arterio Sclerotic Heart Disease
(b) 4 yrs.Due To
(c)

OTHER SIGNIFICANT CONDITIONS Cerebral Atrophy

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) Frederick Ornsteen M. D.
Frederick Ornsteen
(PRINT OR TYPE SIGNATURE)

(Address) 131 Washington Ave Date 9/13/63

6 Chelsea Mass Peabody
Cremation Oak Hill (City or Town)

DATE OF BURIAL September 15, 1963

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach

ADDRESS 10 Washington St. Dorchester

Received and filed SEP 16 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Widowed
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Philip Greenspan
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER Zelig Oxman

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Rebecca-Cannot be lear

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant Benny Greenspan (son)
(Address) 617 Morton St., MattapanI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) (16-23)

Health Officer Sept 14 1963
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

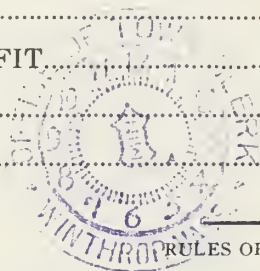
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending Physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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(for burial permit
ard of Health
ts Agent.

DUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
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etc. It means
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death but not
to the terminal
condition given

C.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

No. 214 Somerset Ave.,

STANDARD CERTIFICATE OF DEATH

Registered No. 176

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR) No

2 FULL NAME Miriam F. Macken

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 214 Somerset Ave
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 14, 1963

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Sept. 6, 1962, to Sept. 14, 1963

I last saw her alive on 9/13/63 death is said to
have occurred on the date stated above, at 4:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Breast

Due To with generalized
(b) metastases

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical Pathological

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 9/14/1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 17 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed SEP 16 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Married
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of James T. Macken
(Husband's name in full)

12 AGE 45 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. Medford

16 BIRTHPLACE (City) Mass

17 NAME OF FATHER Frederick Wholley

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Mary McCormack

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant James T. Macken
(Address) 214 Somerset Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Liberman
(Signature of Agent of Board of Health or other)
Health Officer Sept 16, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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SEP 16 1963 AM

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

X

PLACE OF DEATH

Plymouth

(County)

Bridgewater

(City or Town)

No. M.C.I. Bridgewater, Mass.

The Commonwealth of Massachusetts



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Bridgewater

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 177

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Francis A. Roberts

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, WW1 if so specify WAR)

(a) Residence. No.

74 Read

(Usual place of abode)

St.

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death years months 4 days. In place of residence ? years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 14, 1963

(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 63 to Sept. 14, 63

I last saw him on Sept. 14, 1963 death is said to have occurred on the date stated above, at 3p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH dys

(b) Due To Arteriosclerosis Disease yrs

(c) Due To Pulmonary T.B. yrs

OTHER SIGNIFICANT CONDITIONS Chronic Alcoholism yrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Ivan Iturralde, M. D.

(Address) M.C.I. Bridgewater 9/14 1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 17, 1963

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS Winthrop, Mass.

Received and filed SEP 24 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M

9 COLOR

W

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Anna McLaughlin

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 76 Years 11 Months 15 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Retired

(Kind of work done during most working life)

14 Industry

or Business:

15 Social Security No. 047-20-6920

16 BIRTHPLACE (City) Champlain, N.Y.
(State or country)

17 NAME OF

FATHER

Augustus Roberts

18 BIRTHPLACE OF

FATHER (City)

Champlain,

(State or country)

N.Y.

19 MAIDEN NAME

OF MOTHER

Mary Senecal

20 BIRTHPLACE OF

MOTHER (City)

Champlain

N.Y.

(State or country)

21 Informant

(Address)

M.C.I. Bridgewater, Mass.

A TRUE COPY

ATTEST:

Jennie C. Carroll
(Registrar of City or Town where death occurred)

DATE FILED

Sept. 20, 1963

19

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....9/20/1917
DATE OF DISCHARGE.....6/12/1918
RANK, RATING.....Private
ORGANIZATION AND OUTFIT.....Battery C, 301st Field Artillery
SERVICE NUMBER.....1662912

SEP 24 1963 AM

SEP 24 1963 AM

INSTRUCTIONS
FOR
CERTIFICATEn giving
OF DEATHnot enter
e than one
e for each
, (b) and (c)does not mean
e of dying,
heart failure,
etc. It means
ase, or compli-
which causedtions, if any,
gave rise to
cause (a),
g the under-
cause last.ditions contrib-
o death but not
to the terminal
condition givenChapter 137,
1954, requires
ans to print or
he cause or
of death on
ertificates, and
48, Acts of
quires Physi-
print or type
nder signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 178

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Elizabeth Cone (Knox)
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. 63 Harbor View Avenue
(Usual place of abode)St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....6.....days. In place of residence.....65.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 15, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
June, 1950, to Sept. 15, 1963
I last saw her alive on Sept. 15, 4:20 p.m., death is said to
have occurred on the date stated above, at 4:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebro-vascular Hemorrhage

INTERVAL
BETWEEN
ONSET AND
DEATH

3 days

Due To Arteriosclerosis, generalized
(b) yearsDue To Hypertension, essential
(c) yearsOTHER SIGNIFICANT CONDITIONS Diabetes Mellitus
Hydrops of Gallbladder

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Gregorie, M.D.

Joseph Gregorie, M.D.
(PRINT OR TYPE SIGNATURE)(Address) 194 Washington Ave. Sept. 15, 1963
Winthrop, Mass.6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 18, 1963

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed SEP 17 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED widow10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of John W Cone
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years 6 Months 17 Days
If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Everett
(State or country) Mass.

17 NAME OF FATHER Alexander Knox

18 BIRTHPLACE OF FATHER (City) Paisley
(State or country) Scotland

19 MAIDEN NAME OF MOTHER Emma Tewksbury

20 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Mass.21 Informant Frank A Baumeister
(Address) 24 Perkins St. Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sullivan (B)
(Signature of Agent of Board of Health or other)Health Officer Sept 17, 1963
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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RECEIVED



SEP 17 1963 PM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

PLACE OF DEATH

SUFFOLK

(County)

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 179

No. Cee Ardith Johnson (Jones)
(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME.....
(If deceased is a married, widowed or divorced woman, give also maiden name.)

34 Seafoam Ave., Winthrop, Mass.

(a) Residence. No. St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

INSTRUCTIONS
FOR
CERTIFICATEgiving
OF DEATHnot enter
e than one
e for each
(b) and (c)does not mean
de of dying,
heart failure,
etc. It means
use, or compli-
which causedions, if any,
gave rise to
cause (a),
the under-
cause last.ditions contrib-
death but not
to the terminal
condition givenChapter 137,
1954, requires
ns to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept 16 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
Sept 16 to Sept 16 1963
I last saw h.....alive on Sept 16 1963, death is said to
have occurred on the date stated above, at 10:30 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion
Coronary Artery Heart
Disease.
Due To (b) None

Due To (c) None

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? YES

What test confirmed diagnosis? Charles E. Liberman

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) WINTHROP, MASS 9/16/63, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) Date.....19.....

6 Winthrop Cemetery, Winthrop, Mass.,
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 19, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed SEP 19 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED widowed
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Carleton Johnson
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 8 Months 12 Days If under 24 hours Hours.....Minutes

13 Usual Occupation: practical nursing
(Kind of work done during most of working life)

14 Industry or Business: self employed

15 Social Security No. 021-07-8043

16 BIRTHPLACE (City) Rockland
(State or country) Maine

17 NAME OF FATHER C. Frank Jones

18 BIRTHPLACE OF FATHER (City) Rockland
(State or country) Maine

19 MAIDEN NAME OF MOTHER Ermina Greenlaw

20 BIRTHPLACE OF MOTHER (City) Deer Isle
(State or country) MaineInformant Robert Johnson
(Address) 34 Seafoam Ave. Winthrop,I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issuedRalph E. Suranne (B)
(Signature of Agent of Board of Health or other)Health Officer Sept 19, 1963
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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SEP 19 1963 PM

For burial permit
of Health
s Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

oes not mean
e of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
to the terminal
condition given

c.

The Commonwealth of Massachusetts



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 101 Johnson Ave

STANDARD CERTIFICATE OF DEATH

Registered No. 180

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Francis E. Dacey
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(a) Residence. No. 101 Johnson Ave
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 6 years.....months.....days. In place of residence 6 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 18, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 18, 1963, to Sept 18, 1963.
I last saw her live on Sept 11, 1963 death is said to

have occurred on the date stated above, at 7-45A.m.

DEATH CAUSED BY: IMMEDIATE CAUSE

(a) Hypostatic Congestion of Lungs
(b) Asphyxia

(c) Acute Cardiac Failure

OTHER SIGNIFICANT CONDITIONS Coronary insufficiency

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Leon W. Crockett, M. D.

(Print or Type Name) Leon W. Crockett

(Address) 32 Main St. Charlestown Date 9/18/63

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 21, 1963

7 NAME OF FUNERAL DIRECTOR Joseph P. Murphy

322 Bunker Hill St. Charlestown

ADDRESS

Received and filed SEP 19 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married

11 If married, widowed, or divorced HUSBAND of Helen F. Murphy
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

AGE 62 Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation Self-employed
(Kind of work done during most working life)

14 Industry or Business Screen and Shade Co

15 Social Security No. 014-18-2371

16 BIRTHPLACE (City) Chelsea
(State or country)

17 NAME OF FATHER William T. Dacey

18 BIRTHPLACE OF FATHER (City) Boston
(State or country)

19 MAIDEN NAME OF MOTHER Mary Cummings

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country)

21 Informant Helen F. Dacey
(Address)

101 Johnson Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer Sept 19, 1963

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 19 1963 PM

Suffolk

(County)

Winthrop Mass

(City or Town)

Winthrop Community Hospital

No.

PLACE OF DELIVERY

2 NAME OF FETUS
(if given)

Baby Girl Leone

The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

Registered No. 181

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)3 DATE OF DELIVERY 9 19 63
(Month) (Day) (Year)4 SEX
Male.....Female. ☒ Undetermined.5 COLOR (if determined)
White6 THIS BIRTH (Check one)
Single ☒ Twin.. Triplet7 IF MULTIPLE BIRTH, BORN:
1st.....2nd... 3rd8 FULL NAME
John Leone

FATHER

14 MAIDEN NAME Anna Navarro
PRESENT NAME Anna Leone

MOTHER

9 RESIDENCE, NO. 42 Gove St.
CITY OR TOWN East Boston STATE Mass15 RESIDENCE, NO. 42 Gove St
CITY OR TOWN East Boston STATE Mass

10 COLOR OR RACE White 11 AGE AT TIME OF THIS DELIVERY 34 (Years)

16 COLOR OR RACE White 17 AGE AT TIME OF THIS DELIVERY 25 (Years)

12 PLACE OF BIRTH East Boston Mass
(City or Town) (State or country)18 PLACE OF BIRTH Italy
(City or Town) (State or country)

13 OCCUPATION Shoe Worker

19 INFORMANT Husband

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus)
None(a) How many children are
now living? None(b) How many children were
born alive but are now
dead? 1(c) How many previous fetal
deaths of ANY gestation
age? 1 - 2 mos.

21 LENGTH OF PREGNANCY 9 completed weeks

22 WEIGHT OF FETUS
Lb. 11 Oz
(Grams)23 WHEN DID FETUS DIE?
Before Labor During Labor or Delivery ☒ Unknown24 AUTOPSY
Yes ☒ No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Unknown cause

Due To (b) Term Delivery antepartum death

Due To (c)

OTHER SIGNIFICANT
CONDITIONS

None

26 HOLY CROSS
Place of Burial or CremationMALDEN
(City or Town)

DATE OF BURIAL

9-23-63

19

27 NAME OF FUNERAL DIRECTOR
ADDRESSVINCENT RAPINO
9 CHILSFIELD ST. BOSTON

Received and filed

SEP 20 1963

19

A TRUE COPY ATTEST:

Registrar

I HEREBY CERTIFY that this delivery occurred on the date stated
above at 2 m. and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

D. T. Staffier, M.D.

M.D.

D. T. Staffier, M.D.
(PRINT OR TYPE SIGNATURE)Address 21 Breed Street Date 9/19 19 63
E. Boston, Mass.I HEREBY CERTIFY that a satisfactory certificate of fetal death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Sciarra

(Signature of Agent of Board of Health or other)

Health Officer
(Official Designation)2/20/63
(Date of Issue of Permit)

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscles, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

FORM R-301

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
se, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
a the terminal
condition given

1. C.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Registered No. 182

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

2 FULL NAME Verdi, Andrew E.
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)

(a) Residence. No. 91 Fremont St., Winthrop
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 13 years 47 months 47 days. In place of residence 47 years 47 months 47 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 26, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Sept. 19, 1963, to Sept. 26, 1963
I last saw him live on Sept. 25, 1963 death is said to
have occurred on the date stated above, at 3:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

(b) arteriosclerosis-gen

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Joseph P. Caggiano, M. D.

(Print or Type Name)

(Address) 19 Washington St. Date 9/25/63

6 Winthrop Winthrop Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 30 1963

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St. Winthrop

Received and filed SEP 30 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Helen G. O'Reilly
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 88 10 9 AGE Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Storekeeper (Kind of work done during most working life)

14 Industry or Business: Variety Store

15 Social Security No. 021-26-8165

16 BIRTHPLACE (City) Plymouth
(State or country) England

17 NAME OF FATHER George Verdi

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Helen Talepartria

20 BIRTHPLACE OF MOTHER (City) Greece
(State or country)

21 Informant (Address) Mrs. Billie Broder
34 Sunset Rd, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

SEP 30 1963 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
le of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
o the terminal
condition given

PLACE OF DEATH

Suffolk
(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Ferrara, Baby Boy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 225 Endicott Ave
(Usual place of abode)

St. Revere
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 9 27 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
SEPT 27 1963, to SEPT 27 1963
I last saw him live on SEPT 27 1963 death is said to
have occurred on the date stated above, at 11:20 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) HYALINE MEMBRANE DS

Due To (b) PREMATUREITY

Due To (c)

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL & X-RAY

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King M. D.
MYRON N. KING M.D.
(Print or Type Name)
(Address) 12 PLEASANT ST. WINTHROP
Date 9/28/63

6 Woodlawn Everett Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 28 1963

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 14 Winthrop St Winthrop

Received and filed SEP 30 1963 19

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 183

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE Years Months Days If under 24 hours 2 Hours Minutes

13 Usual Occupation: None (Kind of work done during most working life)

14 Industry or Business: None

15 Social Security No.

16 BIRTHPLACE (City) Winthrop Mass (State or country)

17 NAME OF FATHER John Ferrara Jr.

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass

19 MAIDEN NAME OF MOTHER Joan Nolan

20 BIRTHPLACE OF MOTHER (City) Revere (State or country) Mass

21 Informant John Ferrara (Address) 225 Endicott Ave Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) Health Officer 9/28/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit
of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

oes not mean
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heart failure,
etc. It means
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death but not
to the terminal
condition given

c.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 184

No. 11 TRIDENT Ave

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ISADORE BRAVERMAN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence. No. 11 TRIDENT Ave
(Usual place of abode)

St. WINTHROP
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 2.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 28 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Feb. 19. 63, to Sept. 28, 1963
I last saw him live on Sept. 27, 1963, death is said to
have occurred on the date stated above, at 9:00A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Emphysema 10yrs

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease Emphs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 9/28/1963

6 STARO-CONSTANTINO W. Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 29 1963

7 NAME OF FUNERAL DIRECTOR TORI Funeral Service Inc.
ADDRESS 151 Washington Ave Chelsea

Received and filed SEP 30 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M	9 COLOR White	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN MARRIED
------------	------------------	--

11 If married, widowed or divorced
HUSBAND of Sophie HOFFMAN
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 72 Years Months Days
If under 24 hours Hours Minutes

13 Usual Occupation CABINET MAKER
(Kind of work done during most working life)

14 Industry or Business FURNITURE MFG.

15 Social Security No.

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER NATHAN BRAVERMAN

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER SARAH CBL

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant HAROLD BRAVERMAN
(Address) 11 TRIDENT Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 7/29/63

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

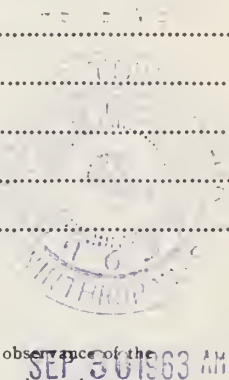
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



For burial permit
and of Health
Agent.

CTIONS
OR
CERTIFICATE

OR TYPE
CAUSES
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b) and (c)

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 185

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Marion Hall (Cole)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 16 Lincoln St.

(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death 1/2 hour years months days. In place of residence 35 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 30, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
May 1960, to Sept. 30, 1963

I last saw him alive on Sept. 30, 1963 death is said to
have occurred on the date stated above, at 2:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

Due To

(b) atherosclerosis gen

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph E. Gregory, M. D.

(Address) 194 Washington Ave. Date 9/30 1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 2 1963

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed OCT 1 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widow

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
Clifford A. Hall

(or) WIFE of (Husband's name in full)

12 AGE 72 Years 9 Months 1 Days If under 24 hours
Hours Minutes

13 Usual Occupation Admission clerk
(Kind of work done during most working life)

14 Industry or Business Hospital

15 Social Security No. 013-28-5498

16 BIRTHPLACE (City) Cambridge
(State or country) Mass

17 NAME OF FATHER Charles Cole

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Laura A. Cleveland

20 BIRTHPLACE OF MOTHER (City) Carmel
(State or country) Maine

21 Informant Mildred Canbline
(Address) 16 Lincoln St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Keith E. Johnson (Signature of Agent of Board of Health or other)
Health Officer (Official Designation) Oct 1, 1963 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook, hotel, etc. For a person who had no occupation whatever write none.

OCT 1 1963 AM

M R-303

ed for burial permit
Board of Health
r its Agent.

WRITE PLAINLY WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, § 6, 20; Chap. 46, §§ 9, 10; Chap. 114, § 14.

Declassified was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M 382-932695

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

OUT - OF - TOWN 186

(City or Town making this return)

Registered No. 07806

No. 215 Charles St., Boston

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME JOHN J GORMAN

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

if so specify WAR) WW #2

240 Pleasant Street

Winthrop, Massachusetts

(a) Residence. No. St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 5.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 29, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Asphyxia, due to hanging.

5 Accident, suicide, or homicide (specify) Suicide.

Date and hour of injury July 29, 1963

IF ACCIDENTAL, was injury causally related to the death?

Where did injury occur? Boston, Massachusetts

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or public place? Cell-door of Jail

(Specify type of place)

Manner of Injury Suspension by undershirt.

(How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? Yes.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.

(Address) Boston (Print or Type Name) 7/30 63

7 Mt. St. Mary's Pawtucket, R.I.

(City or Town)

DATE OF BURIAL August 1 1963

8 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed AUG 2 1963

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

Male

10 COLOR

White

11 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Married

12 If married, widowed, or divorced

HUSBAND of Catherine Boland

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE

46

Years

Months

Days

If under 24 hours

Hours Minutes

14 Usual Occupation:

Medical Doctor

(Kind of work done during most of working life)

15 Industry or Business:

Pediatrician

16 Social Security No.

039-10-8125

17 BIRTHPLACE (City)

Central Falls

(State or country)

Rhode Island

18 NAME OF FATHER

James H. Gorman

19 BIRTHPLACE OF FATHER (City)

(State or country)

England

20 MAIDEN NAME OF MOTHER

Margaret Dalton

21 BIRTHPLACE OF MOTHER (City)

(State or country)

Ireland

22

Informant (Address)

Catherine Gorman

240 Pleasant St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. B. Gerson

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane

Clerk

2200000000

RECEIVED



OCT 3 1963 PM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
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cause (a),
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ditions contrib-
death but not
to the terminal
condition given

Director

use only

CK Ink.

17 1963

5-2-933404

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)



No. MASSACHUSETTS GENERAL HOSPITAL

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 08188

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Eva Hambro

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, no.
if so specify WAR)

(a) Residence. No. 155 River Road
(Usual place of abode)

s. Winthrop, Massachusetts
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 8 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
August 1, 19. 63, to August 8, 19. 63.
we last saw her live on August 8, 19. 63 death is said to

have occurred on the date stated above, at 6:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Fracture of right hip

INTERVAL
BETWEEN
ONSET AND
DEATH

1 week

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased?

If so, specify *Ch. Clay*

(Signature) *Charles L. Clay, M.D.*, M. D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Aug. 8, 19. 63.

6 Hand in Hand West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 9, 19. 63

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline

Received and filed19.....

William J. Kane
A TRUE COPY ATTEST:

AUG 12 1963
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Morris Hambro
(Husband's name in full)

12 AGE 90 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City)..... Germany
(State or country)

17 NAME OF FATHER Abraham Mayer

18 BIRTHPLACE OF FATHER (City)..... Germany
(State or country)

19 MAIDEN NAME OF MOTHER Caroline (unknown)

20 BIRTHPLACE OF MOTHER (City)..... Germany
(State or country)

21 Informant Mrs. Harold Rosen
38 Embassy Road, Brighton, Mass.
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

E. W. Ward
(Signature of Agent of Board of Health or other)
(Official Designation) 8-9-63
(Date of Issue of Permit)

MEDICAL EXAMINER TO COUNTERSIGN

RECEIVED



OCT 17 1963 AM 1

A True and Correct

William J. Kane.
Town Clerk

FORM R-301

For burial permit
rd of Health
s Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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than one
for each
(b) and (c)

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e of dying,
heart failure,
etc. It means
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which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
condition given

MEDICAL EXAMINER DECLINED JURISDICTION

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

No. PETER BENT BRIGHAM HOSPITAL

2 FULL NAME Harry Blaustein

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 144 Quincy Avenue

(Usual place of abode)

x. Winthrop 52, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....1.....days. In place of residence 15 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 24, 1963

4 I HEREBY CERTIFY, That we attended deceased from August 23, 1963, to August 24, 1963. I last saw him alive on August 24, 1963, death is said to have occurred on the date stated above, at 2:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Ventricular fibrillation

(b) Due To Myocardial Infarction

(c) Due To Arteriosclerotic and Hyper-tensive heart disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) DAVID D. ULMER, M.D.

(Print or Type Name)

PETER BENT BRIGHAM HOSPITAL August 24, 1963

6 SHARON MEM. PARK SHARON

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL AUGUST 25, 1963

7 NAME OF FUNERAL DIRECTOR ARNOLD GOLOV

ADDRESS 1668 BEACON ST. BROOKLINE

Received and filed AUG 27 1963

William J. Kane (Registrar)

A TRUE COPY ATTEST

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

188

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 08626

{(If death occurred in a hospital or institution, give its NAME instead of street and number) PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran, if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of GOLDIE BONNER (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 64 Years. Months. Days If under 24 hours Hours. Minutes

13 Usual Occupation PAINTER-CONTRACTOR (Kind of work done during most of working life)

14 Industry or Business: RETIRED

15 Social Security No. 034-14-3368

16 BIRTHPLACE (City or country) BROOKLYN, N.Y.

17 NAME OF FATHER SAMUEL BLAUSTEIN

18 BIRTHPLACE OF FATHER (City) RUSSIA (State or country)

19 MAIDEN NAME OF MOTHER ANNA CNBL

20 BIRTHPLACE OF MOTHER (City) ROMANIA (State or country)

21 Informant WILLIAM BLAUSTEIN

(Address) 14 CARPENTER RD. LYNNFIELD

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

7. P. Kane 309311 (Signature of Agent of Board of Health or other)

(Official Designation) AUG 25 1963 (Date of Issue of Permit)

2-933404

A TRUE COPY

RECEIVED



OCT 17 1963 AM

For burial permit
rd of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
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(b) and (c)

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etc. It means
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which caused

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death but not
to the terminal
condition given

7 1963

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70

Director
use only
CK Ink.

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

PLACE OF DEATH

No. MASSACHUSETTS GENERAL HOSPITAL

Mary M. Pelletier

2 FULL NAME Mary M. Pelletier

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 33 Atlantic

(Usual place of abode)

st. Winthrop Mass.

(City or town and State)

Length of stay: In place of death. years 1 months 11 days. In place of residence. years 2 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25 63

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from July 11 1963, to August 25 1963.

We last saw her alive on August 25 1963, death is said to

have occurred on the date stated above, at 10:15am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Ruptured Aneurysm R Anterior Cerebral Artery

(b) Essential Hypertension

(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

6 Wks

Unknown

OTHER SIGNIFICANT CONDITIONS Pneumonia, B. Pyocyaneus

4 Wks

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. L. Clay, M. D.

Charles L. Clay, M. D.

(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date August 25 1963

6 New Calvary Cemetery Boston

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL August 28, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

Registered No. 08697

{(If death occurred in a hospital or institution, give its NAME instead of street and number)
PHYSICIAN — IMPORANT

{(Was deceased a U. S. War Veteran, if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Leo W. Pelletier

(Husband's name in full)

12 AGE 57 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Sail maker

(Kind of work done during most of working life)

14 Industry or Business: Sails

15 Social Security No. 030-03-1090

16 BIRTHPLACE (City) Jamaica Plain

(State or country) Mass.

17 NAME OF FATHER Andrew J. O'Connell

18 BIRTHPLACE OF FATHER (City) Ireland

19 MAIDEN NAME OF MOTHER Bridget Green

20 BIRTHPLACE OF MOTHER (City) Ireland

(State or country)

21 Informant Leo W. Pelletier

(Address) 33 Atlantic St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

12552

(Official Designation)

8-26-63

(Date of Issue of Permit)

A TRUE COPY ATTEST:

RECEIVED



OCT 17 1963 AM

A TRUE COPY

Winthrop Mass.

for burial permit
Board of Health
to Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
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(b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
cause, or compli-
which caused

itions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

OUT - OF - TOWN

Suffolk

(County)

Boston

(City or Town)

No. New England Deaconess Hospital

2 FULL NAME Mr. Philip Emma
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 158 Circuit Road
(Usual place of abode)

St. Winthrop, Massachusetts

(City or town and State)

Length of stay: In place of death. years. months. 26 days. In place of residence 8 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 26, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
July 31, 1963, to August 26, 1963.I last saw him alive on August 26, 1963 death is said to
have occurred on the date stated above, at 7:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hepatic Failure

(b) Biliary & Portal obstruction.

(c) Massive Metastases - Carcinoma
of rectum

OTHER SIGNIFICANT CONDITIONS Diffuse Arteriosclerosis several years.

Was autopsy performed? Yes.

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Joseph T. Ostroski, M. D.

(Address) NEDH (Print or Type Name) Date 8/27 1963

6 St. Michael Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 30 1963

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
147 Winthrop St., Winthrop

ADDRESS

Received and filed AUG 30 1963

(Registrar) J. Kane

A TRUE COPY ATTEST.

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATH

Registered No. 08782

{(If death occurred in a hospital or institution
give its NAME instead of street and number)
PHYSICIAN - IMPORTANT{(Was deceased a
U. S. War Veteran,
if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED married
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of V. Sadie Micciche
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 60 years 6 Months 11 Days If under 24 hours
Hours Minutes13 Usual Occupation Printer
(Kind of work done during most of working life)

14 Industry or Business Printing

15 Social Security No. 010-05-6892

16 BIRTHPLACE (City)
(State or country) Italy

17 NAME OF FATHER Charles Emma

18 BIRTHPLACE OF FATHER (City)
(State or country) Italy

19 MAIDEN NAME OF MOTHER Lillian Locigno

20 BIRTHPLACE OF MOTHER (City)
(State or country) Italy21 Informant V. Sadie Emma
158 Circuit Rd., Winthrop
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:(Signature of Agent of Board of Health or other)
175-99 8/29/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.

RECEIVED



OCT 17 1963 AM

Registered No.

(County)

Boston

(City or Town)



No. En Route East Boston Police (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Uenos, Ford (Gooding) (First Name) (Middle Name) (Last Name) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. _____ St. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence ²⁵.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept 1 1963
(Month) (Day) (Year)

41 HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did
Injury occur?
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?

Manner of Injury

Nature of Injury
While at work? Was autopsy performed?

While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Seare, W. H., M. D.

George W. Kuntz
(Print or Type Name)

(Address) 784 Mass Dat Sept 1 1903
Winthrop Cemetery Winthrop

Place of Burial or Cremation, (City or Town) Sept 5 1963

DATE OF BURIAL

8 NAME OF FUNERAL DIRECTOR Ernest P Caggiano
147 Anthrop St. Anthrop

Received and filed SEP 8 1966

A TRUE COPY ATTEST: *William J. Isaac* (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE (write the word)
Female	White	MARRIED WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced
HUSBAND of (Give full name of wife in full)
(or) WIFE of John J. Ford (Husband's name in full)

13 AGE 65 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation: Laundress
(Kind of work done during most of working life)

15 Industry of Business: Domestic

16 Social Security No. 025 20 9990
17 BIRTHPLACE (City) Vanceboro
(State or country) Maine

18 NAME OF FATHER Mitchell Goodine

19 BIRTHPLACE OF FATHER (City) Frederikson
(State or country) Maine

20 MAIDEN NAME
OF MOTHER Margaret Chesie.

21 BIRTHPLACE OF
MOTHER (City) Frederickson
(State or country) Maine.

22 Informant (Address) John Goodine
23 Catherine Rd Bryantville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Richard Gorman
(Signature of Agent of Board of Health or other)
77670 9-6-63
(Official Designation) (Date of Issue of Permit)

RECEIVED

A TRUE COPY ATTEST:

William J. Kane

City Registrar



OCT 17 1963 AM

or burial permit
rd of Health
s Agent.

CTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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of dying,
heart failure,
etc. It means
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itions contrib-
death but not
the terminal
condition given

583
5107

30 1963

Director
use only
CK Ink.

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

PLACE OF DEATH



No. MASSACHUSETTS GENERAL HOSPITAL

(Lungren)

2 FULL NAME Martha Ingraham

(If deceased is a married, widowed or divorced woman, give also maiden name.)

197 A Sherry Street

(a) Residence, No.

(Usual place of abode)

St.

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 9 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from September 4 1963 to September 9 1963

or last saw him alive on September 9 1963 death is said to

have occurred on the date stated above, at 11:17a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) HEMORRHAGE INTO UPPER

G. I. TRACT

(b) HEPATITIS

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) C. C. Clay, M. D.

Charles C. Clay, M.D.

(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Sept. 9, 1963

6 Mt. Auburn Cambridge

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Sept. 11 1963

7 NAME OF FUNERAL DIRECTOR Vincent J. Mazzarella

ADDRESS 971 Saratoga St. East Boston

Received and filed 19 63

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

Registered No.

09173

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT(Was deceased a
U. S. War Veteran, No
if so specify WAR)

St.

(City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Married
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of George Ingraham

(Husband's name in full)

12 AGE 63 Years 7 Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: Nurse

(Kind of work done during most of working life)

14 Industry
or Business:

15 Social Security No. 030-14-5607

16 BIRTHPLACE (City) Hartford, Conn.
(State or country)

17 NAME OF FATHER C.B.L.

18 BIRTHPLACE OF FATHER (City) C.B.L.
(State or country)

19 MAIDEN NAME OF MOTHER C.B.L.

20 BIRTHPLACE OF MOTHER (City) C.B.L.
(State or country)

21 Informant George Ingraham

(Address) 497A Shirley St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued.D. Sanpogna BO 9657
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

(Registrar)

William J. Kane

SEP 25 1963

9/10/63

V.B.

A TRUE COPY ATTEST:

1/1-12-12.

W. H. H. H.

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OCT 30 1963 AM

For burial permit
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DUCTIONS
FOR
CERTIFICATE

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30 1963

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON 193
(City or Town making this return)

Suffolk

(County)

Boston

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 09329

No. Veterans Administration Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. William LEVIN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, WW I
if so specify WAR)

(a) Residence, No. 62 Shore Drive
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, years 1 months 17 days. In place of residence, years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 15 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
July 29 1963 to September 15 1963

XXXXXXXXXXXXXXXXXXXX death is said to
have occurred on the date stated above, at 11:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic carcinoma
of colon

Due To
(b)

Due To
(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

years

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical & Lab. findings

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Kevin D. O'Brien, M.D.
KEVIN D. O'BRIEN, M.D.
(Address) VA Hospital, Boston Sept. 16, 63
(Date)

6 Fuller St Cem. Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 17 1963

7 NAME OF FUNERAL DIRECTOR Levine Funeral Home

ADDRESS 470 Harvard St. Brookline, Mass.

Received and filed SEP 19 1963

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Pauline Kramer
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 72 Years 7 Months 11 Days If under 24 hours
Hours Minutes

13 Usual Occupation Retired accountant
(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

17 NAME OF FATHER Simon Levin

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Minna Bernstein

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant VA Hospital Records
150 So. Huntington Ave.
(Address) Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)
17837 9/16/63
(Official Designation) (Date of issue of permit)

A TRUE COPY ATTEST:

VB.

A TRUE COPY ATTEST:

William J. Lane.

City Registrar

RECEIVED



OCT 30 1963 AM

burial permit
of Health
Agent.

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PLACE OF DEATH

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)



No. MASSACHUSETTS GENERAL HOSPITAL

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 09443

2 FULL NAME Emerald Emery
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, Y
if so specify WAR)

(a) Residence, No. 61 Marshall Street
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 10 years 35 months 25 days. In place of residence 25 years 35 months 25 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 18 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That deceased from
September 8 1963 to September 18 1963
last saw him alive on September 18 1963 death is said to
have occurred on the date stated above, at 12:05a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia 4 Days(b) Aspiration Pneumonia 6 Days(c) Left Cerebral Infarct 10 Days

OTHER SIGNIFICANT CONDITIONS Coronary Heart Disease
Severe Vrs.

Was autopsy performed? YesWhat test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify Ch. Clay

(Signature) Charles L. Cloy, M.D., M. D.

Charles L. Cloy, M.D.
(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Sept. 18, 63

6 Place of Burial or Cremation Winthrop
(City or Town)

DATE OF BURIAL SEP 23 19637 NAME OF FUNERAL DIRECTOR William J. Kane

ADDRESS

Received and filed SEP 23 1963

William J. Kane
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of John St. Laurent
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

12 AGE 2 Years 11 Months 24 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Police Officer (retired)
(Kind of work done during most of working life)

14 Industry or Business: Boston Police Dept.

15 Social Security No. 020-24-1007

16 BIRTHPLACE (City) Lowell
(State or country)

17 NAME OF FATHER John St. Laurent

18 BIRTHPLACE OF FATHER (City) Lowell, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER John St. Laurent

20 BIRTHPLACE OF MOTHER (City) Lowell, Mass.
(State or country)

21 Informant John St. Laurent

(Address) _____
I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

17849 89/9/63
(Official Designation) (Date of Issue of Permit)

V.B.V.

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



OCT 30 1963 AM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

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OUT - OF - TOWN

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)

No. Veterans Administration Hospital

WILLIAM F. FURNISS

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

(Usual place of abode)

366 Pleasant

s. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death..... years 2 months 26 days. In place of residence..... life years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 18 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That VA attended deceased from June 23 1963, to September 18 1963

death is said to have occurred on the date stated above, at 7:10 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Glioblastoma multiform of temporal parietal regional

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? Clinical & Laboratory5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) John C. Daloo M.D., M.D.

(Address) VAH Boston, Mass. Sept. 19 63

6 Winthrop Cem. Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 21 1963

7 NAME OF FUNERAL DIRECTOR O'Malley Funeral Home

ADDRESS 79 Atlantic St., Winthrop, Mass.

Received and filed

SEP 23 1963

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON 195

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 09445

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran, WW2
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED Married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed, or divorced
HUSBAND of Mary G. Donovan
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 53 Years 7 Months 10 Days
If under 24 hours Hours Minutes13 Usual Occupation Office Manager
(Kind of work done during most of working life)14 Industry
or Business

15 Social Security No. 012-03-0083

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

17 NAME OF

FATHER

Edward

18 BIRTHPLACE OF

FATHER (City)

Worcester

(State or country)

Massachusetts

19 MAIDEN NAME

OF MOTHER

Katherine

20 BIRTHPLACE OF

MOTHER (City)

Boston

(State or country)

Massachusetts

21 Informant VA Hospital Records, 150 So.
Huntington Ave., Boston, Mass.

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

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OCT 30 1963 AM

burial permit
of Health
Agent.

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X OUT OF TOWN

PLACE OF DEATH

SUFFOLK
(County)

Boston
(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return.)

STANDARD
CERTIFICATE OF DEATH

Registered No. 09490

No. Beth ISRAEL HOSPITAL St. (If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME BENJAMIN F. SCHREIBER
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence, No. 185 GROVERS Ave. St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death... years... months... days. In place of residence... years... months... 28/ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT 19 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from SEPT 17 19 63, to SEPT 19 19 63
I last saw him alive on SEPT 19 19 63, death is said to have occurred on the date stated above, at 6:28 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE AND CHRONIC PNEUMOPHILITIS

Due To URETERO LITHIASIS LEFT

Due To

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) David Rosen M. D.

(Address) 730 Brookline Ave. Date SEPT 19 19 63
Boston

6 Chevra Kadusha, (Montvale) Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 22, 19 63

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline.

Received and filed SEP 25 1963

William Kase
A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED married UNKNOWN

11 If married, widowed, or divorced Alice Marcus HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 25 Years... Months... Days If under 24 hours... Hours... Minutes

13 Usual Occupation Merchant (Kind of work done during most of working life)

14 Industry or Business: Fruit

15 Social Security No.

16 BIRTHPLACE (City)... Boston, Mass.
(State or country)

17 NAME OF FATHER David Schreiber

18 BIRTHPLACE OF FATHER (City)... Germany
(State or country)

19 MAIDEN NAME OF MOTHER Hinda Manheimer

20 BIRTHPLACE OF MOTHER (City)... Boston, Mass.
(State or country)

21 Informant Alice Schreiber

(Address) 185 Grovers Ave., Wintthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Robert L. ...
(Signature of Agent of Board of Health or other)

9555 7-21-63
(Official Designation) (Date of Issue of Permit)

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A TRUE COPY ATTEST:

William J. [unclear]
City Registrar

RECEIVED



OCT 30 1963 AM

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Burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWINTHROP
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 197

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 212 Cottage Park Road

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John A. Canavan
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) WW 1(a) Residence. No. 212 Cottage Park Road
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 2 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19 to 19
I last saw him alive on 19, death is said to
have occurred on the date stated above, at 5:40 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

Due To (b) to natural causes,

Due To (c) probably acute coronary

OTHER occlusion based on
SIGNIFICANT history. Winthrop Board of Health
CONDITIONS Charles Liberman, M.D.Was autopsy performed no Charles Liberman, M.D.
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 10/9/1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 5, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed OCT 4 1963

John A. Clark

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED Married
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of Ellen V. Mahoney
(Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)12 AGE 67 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation Clerk
(Kind of work done during most working life)

14 Industry or Business U.S. District Court

15 Social Security No. 012-32-3695

16 BIRTHPLACE (City) East Boston
(State or country) Mass

17 NAME OF FATHER Patrick Canavan

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Emma Dubberley

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)21 Informant Ellen V. Canavan
(Address) 212 Cottage Park Rd., WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Charles Liberman, M.D.
(Signature of Agent of Board of Health or other)Health Officer Oct 9, 1963
(Official Designation) (Date of Issue of Permit)

T 197

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 8-6-18

DATE OF DISCHARGE..... 9-30-21

RANK, RATING Seaman 2nd cl

ORGANIZATION AND OUTFIT..... U.S. Navy

SERVICE NUMBER..... 120-30-82

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



OCT - 4 1963 PM

burial permit
of Health
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 198

SUPPLY
(County)
WINTHROP
(City or Town)



No. *20 SHIRLEY ST*

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME *OSCAR I SUNDBERG*
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) *NO*

(a) Residence, No. *20 SHIRLEY ST.*
(Usual place of abode)

St. *WINTHROP*
(City or town and State)

Length of stay: In place of death *20* years.....months.....days. In place of residence *20* years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *October 5, 1963*
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
March 8, 1962, to *Oct. 4, 1963*
I last saw him alive on *Oct. 4, 1963*, death is said to
have occurred on the date stated above, at *3:20p.m.*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *acute bronchial pneumonia*
right *4 days*

Due To (b) *Carcinoma of the urinary*
bladder *1 1/2 yrs.*

Due To (c)

OTHER SIGNIFICANT CONDITIONS *Old healed tubercu-
losis* *12 yrs.*

Was autopsy performed? *no*

What test confirmed diagnosis? *Clinical & laboratory*

5 Was disease or injury in any way related to occupation of deceased? *NO*
If so, specify

(Signature) *H. Traunstein Jr.*, M. D.

M. Traunstein Jr., M. D.
(Print or Type Name)

(Address) *73 Bartlett Rd.* Date *Oct. 7, 1963*

6 *WINTHROP* *WINTHROP*
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *OCT 2* *1963*

7 NAME OF FUNERAL DIRECTOR *MAURICE W KIRBY*

ADDRESS *WINTHROP*

Received and filed *OCT 7 1963* 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *MALE* 9 COLOR *WHITE* 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN *MARRIED*

11 If married, widowed, or divorced
HUSBAND of *CATHERINE SULLIVAN*
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE *73* Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation *COMPOSITOR* *(RETIRED)*
(Kind of work done during most of working life)

14 Industry or Business *NEWSPAPERS*

15 Social Security No. *011-05-5159*

16 BIRTHPLACE (City) *STOCKHOLM*
(State or country) *SWEDEN*

17 NAME OF FATHER *OSCAR SUNDBERG*

18 BIRTHPLACE OF FATHER (City).....
(State or country) *SWEDEN*

19 MAIDEN NAME OF MOTHER *BABARA* *(UNKNOWN)*

20 BIRTHPLACE OF MOTHER (City).....
(State or country) *SWEDEN*

21 Informant *MRS CATHERINE SUNDBERG*
(Address) *20 SHIRLEY ST WINTHROP*

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Hermann
(Signature of Agent of Board of Health or other)
Health Officer *October 7-63*
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 199

No. 20 Tilestone Rd. (If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Harold E. Williams
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) W.W.1

(a) Residence. No. 20 Tilestone Rd. s. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death 40 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October - 5 - 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw h alive on 19 death is said to have occurred on the date stated above, at 7:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

INTERVAL
BETWEEN
ONSET AND
DEATH
4 HrsDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWINTHROP
BOARD OF HEALTHWas autopsy performed? No
What test confirmed diagnosis? History + Clinical Course5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) John F Collins M.D., M. D.

(Print or Type Name)

(Address) Revere Mass Date 6 Oct 1963

6 Winthrop Cem, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 8, 1963 19

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St., E. Bos.

Received and filed OCT 7 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word) MARRIED Widowed Married DIVORCED UNKNOWN

11 If married, widowed or divorced HUSBAND of Katherine J. Schwarz
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 68 Years 22 Months Days If under 24 hours Hours Minutes

13 Usual Occupation Manager
(Kind of work done during most of working life)14 Industry or Business Steel Forgery
010-03-415215 Social Security No. 010-03-4152
16 BIRTHPLACE (City) East Boston
(State or country)

17 NAME OF FATHER William Williams

18 BIRTHPLACE OF FATHER (City) Vermont
(State or country)

19 MAIDEN NAME OF MOTHER Mable Young

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country)

21 Informant Mrs. Katherine Williams

(Address) 20 Tilestone Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial, or transit permit was issued:

Reph & Liramm B
(Signature of Agent of Board of Health or other)
Health Officer Oct 7, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

V.K.V

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... July 15, 1918

DATE OF DISCHARGE..... Dec. 23, 1918

RANK, RATING..... Pri. 1st. Class

ORGANIZATION AND OUTFIT..... 4th Co. Army

SERVICE NUMBER..... 2798439

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT - 7 1963 AM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 200

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 297 Revere

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
{U. S. War Veteran, W W # 1
{if so specify WAR)

2 FULL NAME Ernest F. Nicolas

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 297 Revere

(Usual place of abode)

St. Winthrop

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....28 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 7, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Nov. 24, 1961, to OCT 7, 1963

I last saw him alive on 10/1/63, death is said to

have occurred on the date stated above, at 5:25 P.m.

INTERVAL
BETWEEN
ONSET AND
DEATH
6 HRS

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY OCCLUSION

Due To ARTERIO-SCLEROTIC HEART

(b) DISEASE

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

CARCINOMA OF RECTUM

2 YRS.

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) Myron D. King, M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 222 Pleasant St., Winthrop Date 10/8/63

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 9, 1963

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave., Revere

Received and filed October 8, 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED

WIDOWED Widowed

or DIVORCED

10a If married, widowed or divorced

HUSBAND of Bessie Corbett

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 5-21-1896

AGE 67

4

16

If under 24 hours

Years Months Days

Hours Minutes

13 Usual

Occupation:

Retired-Compositor

(Kind of work done during most of working life)

14 Industry

or Business:

Newspaper

15 Social Security No.

011-09-5981

16 BIRTHPLACE (City)

Revere

(State or country)

Mass.

17 NAME OF

FATHER

Henri Nicolas

18 BIRTHPLACE OF

FATHER (City)

Holland

(State or country)

19 MAIDEN NAME

OF MOTHER

Louise Simon

20 BIRTHPLACE OF

MOTHER (City)

Cambridge

(State or country)

Mass.

PARENTS

21

Informant

(Address)

Mrs. Joan DePalma

297 Revere St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Raef E. Srivanni (s)

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

October 8 1963

(Date of Issue of Permit)

T VB.V

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... 5/17/17

DATE OF DISCHARGE..... 5/19/19

RANK, RATING

ORGANIZATION AND OUTFIT..... U.S. Coast Guard

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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OCT 8 1963 PM

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 201

Suffolk
(County)

Winthrop
(City or Town)



No. Winthrop Community Hospital

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

Robert

PHYSICIAN — IMPORTANT

2 FULL NAME Obediah Countaway
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, no
if so specify WAR)

(a) Residence, No. 51 Somerset Avenue
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 1 days. In place of residence 65 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 9 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
May 19, 1948, to Oct 9, 1963

1 last saw him live on Oct 8, 1963, death is said to
have occurred on the date stated above, at 8:42 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

(b) arteriosclerosis gen

(c)

OTHER
SIGNIFICANT
CONDITIONS
Cholangitis - cholecyst
itis - cholelithiasis

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify no

(Signature) Joseph Macgane

Joseph GREGGIE

(Address) 94 Washington St. Date 10/9 1963

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 11, 1963

7 NAME OF
FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed OCT 11 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word)
MARRIED widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Winifred Barbara Matthews
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AG 91 Years 6 Months 1 Days If under 24 hours
Hours Minutes

13 Usual Occupation house painter
(Kind of work done during most working life)

14 Industry or Business contractor-self employed

15 Social Security No. 013-28-9245

16 BIRTHPLACE (City) Lunenburg
(State or country) Nova Scotia

17 NAME OF
FATHER Joseph Countaway

18 BIRTHPLACE OF
FATHER (City) Lunenburg
(State or country) Nova Scotia

19 MAIDEN NAME
OF MOTHER Catherine Tanner

20 BIRTHPLACE OF
MOTHER (City) Lunenburg
(State or country) Nova Scotia

21 Informant Mrs. Bradford Rafuse
(Address)

87 Milton St. Arlington

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Jermann (B)
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) October 11, 1963 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RECEIVED
 NEW YORK
 MAY 11 1963 PM
 RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during some illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-301

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PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 202

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ETTA BUDELLOF (MORRIS)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, *no*
if so specify WAR)

8 FORREST STREET

(a) Residence, No.
(Usual place of abode)

St. WINTHROP
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....5.....days. In place of residence.....50.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCT 10 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from
JAN 1959, to OCT 10 1963

I last saw her live on OCT 10 1963, death is said to
have occurred on the date stated above, at 8:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCIDENT

INTERVAL
BETWEEN
ONSET AND
DEATH
6 DAYS

Due To (b) ARTERIO SCLEROTIC HEART DISEASE

Due To (c) + HYPERTENSIVE HEART DIS

5 YRS

OTHER
SIGNIFICANT
CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King M. D.

222 Pleasant St WINTHROP
(Print or Type Name)

() MYRON N. KING Date 10/10 1963

Wintthrop Society
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 13 1963

7 NAME OF FUNERAL DIRECTOR TORI funeral Service

ADDRESS 151 Washington Ave Chelsea

Received and filed OCT 11 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of

(or) WIFE of Nathan Buddelof
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 70 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation Housewife
(Kind of work done during most working life)

14 Industry or Business Room cleaning

15 Social Security No. 720-1-10000

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER (C.B.) Morris

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER C.B.L.

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant (Address) 8 Forrest St Wintthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Kath E. Lennane (B)
(Signature of Agent of Board of Health or other)
Health Officer Oct 11, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

932382

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SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

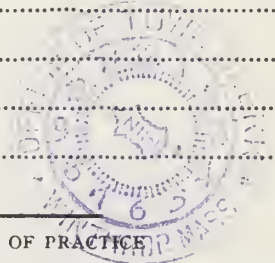
DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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burial permit
of Health
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 203

No. 459 Winthrop St.

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Anna M. Rawston
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) no

(a) Residence. No. 459 Winthrop St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 18 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 11, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
OCT 10, 1963, to OCT 11, 1963.
I last saw him alive on OCT 10, 1963, death is said to

have occurred on the date stated above, at 11 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CARDIAC FAILURE

Due To RHEUMATOID HEART DISEASE

Due To
(c)

INTERVAL
BETWEEN
ONSET AND
DEATH

Minutes

8 YEARS

OTHER
SIGNIFICANT
CONDITIONS

VIRAL BRONCHITIS 3 DAYS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) A. N. Caplan, M. D.

A. N. CAPLAN M.D.
(Print or Type Name)

186 PRINCETON ST EAST BOSTON Date 10-11-1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 14 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed OCT 14 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Robert F. Rawston
(Husband's name in full)

12 AGE 41 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation Clerk
(Kind of work done during most working life)

14 Industry or Business Post exchange

15 Social Security No.

16 BIRTHPLACE (City) East Boston
(State or country) Mass

17 NAME OF FATHER John W. Gay

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Theresa Tierney

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Robert F. Rawston
(Address) 459 Winthrop St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Vignani (Signature of Agent of Board of Health or other)

Health Officer October 14 '63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

T V.B.V.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



OCT 14 1963 AM

burial permit
of Health
Agent.

DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 35, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

204

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME MARY V. G. SCHIVARIE

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a

U. S. War Veteran,

if so specify WAR) NO

(a) Residence. No. 71 Birch Road, Winthrop
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....7 days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 11, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fracture of elbow. Hypertensive cardiovascular disease. Uremia.

5 Accident, suicide, or homicide (specify) Accident.

Date and hour of injury September 21, 19 63

IF ACCIDENTAL, was injury causally related to the death? Yes.

Where did injury occur? Winthrop, Massachusetts
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home.
(Specify type of place)

Manner of injury Fall down cellar stairs.
(How did injury occur?)

Nature of injury

While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M.D.

(Print or Type Name)

(Address) Boston Date 10/11 19 63

7 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT 15 19 63

8 NAME OF FUNERAL DIRECTOR MAURICE W. MYRBY

ADDRESS WINTHROP

Received and filed OCT 14 1963 19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN SINGLE

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE 83 Years Months Days If under 24 hours
Hours Minutes

14 Usual Occupation: CLERK (RETIRED)
(Kind of work done during most of working life)

15 Industry or Business: RESTAURANT

16 Social Security No. 024-09-3566

17 BIRTHPLACE (City) GLOUCESTER
(State or country) MASS

18 NAME OF FATHER ALFRED SCHIVARIE

19 BIRTHPLACE OF FATHER (City)

(State or country) P. E. I.

20 MAIDEN NAME OF MOTHER JUDITH PETERS

21 BIRTHPLACE OF MOTHER (City)

(State or country) P. E. I.

22 Informant LOUIS A. POE
(Address)

71 BIRCH RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scarnum (2)

(Signature of Agent of Board of Health or other)

Health Officer

Oct 14 1963

(Official Designation)

(Date of Issue of Permit)

V.B.V.

RECEIVED

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

OCT 1 4 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

STANDARD
CERTIFICATE OF DEATH

Registered No. 205

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

2 FULL NAME Louisa M (Baxter) Bagness

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 2 Highland Ave
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 10 years 14 months 57 days. In place of residence 57 years 14 months 57 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 13 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
March 12, 1950, to October 13, 1963.I last saw him alive on October 13, 1963, death is said to
have occurred on the date stated above, at 11:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypostatic PNEUMONIA

INTERVAL
BETWEEN
ONSET AND
DEATH

5 DAYS

Due To ACUTE MYOCARDIAL INSUFFICIENCY
(b)

7 DAYS

Due To ARTERIO-SCLEROTIC HEART
(c) DISEASE

7 YEARS

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify(Signed) Dorothy Cherry Appleton, M. D.
DOROTHY CHERRY APPLETON
(PRINT OR TYPE SIGNATURE)(Address) 197 Woodside Ave. Date October 14, 1963
WINTHROP, MASS.6 Winthrop Winthrop
Place of Burial or Cremation Oct. 16, 1963
DATE OF BURIAL7 NAME OF FUNERAL DIRECTOR Howard J. Reynolds
ADDRESS Winthrop, Mass.

Received and filed OCT 16 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED widow

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Alfred T. Bagness
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years 10 Months 23 Days If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Nesbech Cambridgeshire
(State or country) England

17 NAME OF FATHER George J. Baxter

18 BIRTHPLACE OF FATHER (City) Nesbech Cambridgeshire
(State or country) England19 MAIDEN NAME Mary Ann Boyce
OF MOTHER20 BIRTHPLACE OF MOTHER Nesbech Cambridgeshire
(City) England
(State or country)21 Informant A. Howard Bagness
(Address) 4 Highland Ave. Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sircann (B)
(Signature of Agent of Board of Health or other)Health Officer (Official Designation) Oct 16, 1963
(Date of Issue of Permit)

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SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



OCT 16 1963 PM

M R-301

burial permit
of Health
Agent.

TIONS

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return,

STANDARD
CERTIFICATE OF DEATH

Registered No. 206

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. 241 WASHINGTON AVE

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edward L Fitzgerald
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(a) Residence. No. 241 Washington Ave.
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death 2 years.....months.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October - 13 - 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
19....., 19....., to....., 19.....I last saw h..... alive on....., 19....., death is said to
have occurred on the date stated above, at 12.45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

INTERVAL
BETWEEN
ONSET AND
DEATH
12 HrsDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? No
What test confirmed diagnosis? Medical - History5 Was disease or injury in any way related to occupation of deceased NO
If so, specify

(Signature) John F. Collins MD, M. D.

John F. Collins MD

(Print or Type Name)

(Address) Rensselaer Mass Date 14 Oct 1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT 14 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed OCT 14 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

MALE WHITE MARRIED
WIDOWED
DIVORCED
UNKNOWN DIVORCED

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 40 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: LEAD MAN
(Kind of work done during most of working life)

14 Industry or Business: MACHINERY G.E.

15 Social Security No. 025-03-2424

16 BIRTHPLACE (City)... EAST BOSTON
(State or country) MASS

17 NAME OF FATHER MICHAEL H FITZGERALD

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country)

19 MAIDEN NAME OF MOTHER ELIZABETH DALEY

20 BIRTHPLACE OF MOTHER (City) EAST BOSTON
(State or country) MASS

21 Informant WILLIAM FITZGERALD

(Address) 19 PLEASANT COURT WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Sullivan (3)

(Signature of Agent of Board of Health or other)

Health Officer OCT 14 1963

(Date of Issue of Permit)

T V.B. ✓

A TRUE COPY ATTEST:

RECEIVED



SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit
of Health
Agent.

DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-62-932695

PLACE OF DEATH

SUFFOLK

WINTHROP

(City or Town)

41 Cutler Street, Winthrop

No.

St.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Registered No.

207

(City or Town making this return)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

LILLIAN M. SMITH (COX)

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

41 Cutler Street, Winthrop

(a) Residence. No.

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 3 years months days. In place of residence 49 years months 23 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 14, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cirrhosis of liver; uremia;
malnutrition.

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did
injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?

(Specify type of place)

Manner of
injury

(How did injury occur?)

Nature of
injury

While at work? Was autopsy performed?

No.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M.D.

Michael A. Luongo, M.D.

(Address) Boston Date 10/14 1963

7 Winthrop Cemetery, Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 17, 1963

8 NAME OF FUNERAL DIRECTOR Ernest P. Cacciano

ADDRESS 147 Winthrop St., Winthrop

Received and filed

OCT 15 1963

19

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

female white

MARRIED

WIDOWED

DIVORCED

UNKNOWN divorced

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Charles D. Smith

(Husband's name in full)

13

AGE

49 Years

0 Months

23 Days

If under 24 hours

Hours Minutes

14 Usual

Occupation:

Secretary

(Kind of work done during most of working life)

15 Industry

or Business:

Office work

16 Social Security No.

020-09-9206

17 BIRTHPLACE (City)

(State or country)

Winthrop

Mass.

18 NAME OF

FATHER

Richard E. Cox

19 BIRTHPLACE OF

FATHER (City)

Boston

(State or country)

Mass.

20 MAIDEN NAME

OF MOTHER

Lillie B. Jacobs

21 BIRTHPLACE OF

MOTHER (City)

West Newton

(State or country)

Mass.

22

Informant

(Address)

Ruth Donovan

41 Cutler St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seaman (S)

(Signature of Agent of Board of Health or other)

Health Officer

Oct 15 1963

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE
DATE OF DISCHARGE
RANK, RATING
ORGANIZATION AND OUTFIT
SERVICE NUMBER
.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
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STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Revere

(City or Town making this return)

Suffolk

(County)

Revere

(City or Town)



COPY OF
CERTIFICATE OF DEATH

Registered No. 208

Grover Manor Hospital

No. _____ St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Grace K. McCarthy (Harney)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR, _____)

(a) Residence, No. 78 Ingleside Ave.
(Usual place of abode)

x Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death, _____ years _____ months 5 days. In place of residence, 30 years _____ months _____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 16, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 10 53 Oct. 16 63
er, 19 Oct. 16 63, 19, death is said to
I last saw h. alive on _____, 19, death is said to
have occurred on the date stated above, at 1 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Carcinomatosis

(a) Due To Carcinoma Lt. Breast

(b) Due To _____

(c) Due To _____

OTHER SIGNIFICANT CONDITIONS

Acute Cardiac

Insuf.

1963 - Denied

Was autopsy performed? X-ray - Parecentesis

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) Harold L. Musgrave

M. D.

(Address) 620 Beach St. 10/17 63
Revere Date _____ 19 _____

Winthrop

Winthrop

6 Place of Burial or Cremation October 18, 63
(City or Town)

DATE OF BURIAL _____ 19 _____

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

Winthrop

ADDRESS _____

Received and filed NOV 6 - 1963 _____ 19 _____

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word)
Female	White	MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of William S. McCarthy
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

12 AGE 67 Years _____ Months _____ Days
If under 24 hours
Hours _____ Minutes

13 Usual Occupation: Homemaker
(Kind of work done during most working life)

14 Industry or Business: Home

15 Social Security No. none
Revere

16 BIRTHPLACE (City) Mass.
(State or country)

17 NAME OF FATHER Edward Harney

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Catherine Corbett

20 BIRTHPLACE OF MOTHER (City) Newburyport
(State or country) Mass.

21 Informant William S. McCarthy
(Address)

78 Ingleside Ave., Winthrop

A TRUE COPY

ATTEST: _____
(Registrar of City or Town where death occurred)

DATE FILED October 17, 63

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... Oct. 11, 1918

DATE OF DISCHARGE..... Oct. 11, 1920

RANK, RATING..... Yeoman 2/c/ F. Provisional

ORGANIZATION AND OUTFIT..... Navy

SERVICE NUMBER..... 2000558

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PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Winthrop
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 209

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charm, Samuel (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 17 Temple Ave. st. Winthrop, Masa. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death. 1 Hour months days. In place of residence. 11 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 17, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Feb. 1958 to Oct. 17, 1963
I last saw him alive on Oct. 17, 1963, death is said to have occurred on the date stated above, at 3:20 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion, acute 2 hrs. INTERVAL BETWEEN ONSET AND DEATH

Due To (b) Arteriosclerotic Heart Disease 5 yrs

Due To (c) Myocardial Infarction 3 1/2 yrs

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus 3 1/2 yrs

Was autopsy performed?

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.

(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 10/17/1963

6 Sharon Memorial Park, Sharon
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 18, 1963

7 NAME OF FUNERAL DIRECTOR Levine Chapels Inc.

470 Harvard St., Brookline

ADDRESS Harvard 50 Brookline

Received and filed OCT 17 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Vinetta Silverman (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 65 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Retired (Kind of work done during most working life)

14 Industry or Business: Electrician

15 Social Security No. 029-10-5954

16 BIRTHPLACE (City) (State or country) Russia

17 NAME OF FATHER Isaac Charm

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Jennie Blair

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant (Address) Mrs. Vinetta Charm

17 Temple Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph B. Liberman (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) October 7, 1963 (Date of Issue of Permit)

A TRUE COPY ATTEST:

RECEIVED



SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

OCT 17 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 210

No. 24 Taylor Street

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Arthur C. Glendenning
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

(a) Residence. No. 24 Taylor Street
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 15 years.....months.....days. In place of residence 15 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 17 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at 11:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due
(b) to natural causes.

(c) on the basis of
OTHER SIGNIFICANT CONDITIONS generalized arteriosclerosis.
Winthrop Board of Health

Was autopsy performed? Charles Liberman M.D.
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased N
If so, specify

(Signature) Charles Liberman M.D.
(Print or Type Name)
(Address) WINTHROP, MASS. Date 10/18/63

6 Bartlett Cemetery, Bartlett, N.H.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 21, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed OCT 18 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Single
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 82 Years 10 Months 12 Days If under 24 hours
Hours.....Minutes

13 Usual Occupation Retired Rail Road Employee
(Kind of work done during most working life)

14 Industry or Business Maine Central Rail Road

15 Social Security No. 003-01-3577

16 BIRTHPLACE (City) Bartlett
(State or country) New Hampshire

17 NAME OF FATHER James B. Glendenning

18 BIRTHPLACE OF FATHER (City) Bartlett
(State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Margaret Jameson

20 BIRTHPLACE OF MOTHER (City) Bartlett
(State or country) New Hampshire

21 Informant Mrs. Joseph Mundy
(Address)

24 Taylor St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
Mass filed with me BEFORE the burial or transit permit was issued:

Ralph C. Simon (s)
(Signature of Agent of Board of Health or other)
Health Officer October 18 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

RECEIVED



SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 211

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Convalescent Home

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Eunice D (Wilson) Veitch
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
(if so specify WAR)(a) Residence. No. 142 Pleasant St.
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 4 months 25 days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 19, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
12:00, 19 October 1963.
I last saw her alive on Oct 18, 1963, death is said to
have occurred on the date stated above, at 11:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerosis

INTERVAL
BETWEEN
ONSET AND
DEATH
1 mo.

Due To (b) Senility years

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased?
If so, specify NO

(Signed) H.B.G. Greenfield, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 443 Winthrop Ave. Date Oct 19 1963

6 Place of Burial or Cremation Winthrop
(City or Town)

DATE OF BURIAL Oct 21 1963

7 NAME OF FUNERAL DIRECTOR

ADDRESS

Received and filed OCT 21 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Widowed10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Robert A. Veitch
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years 6 Months 6 Days
If under 24 hours
Hours Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 021-03-0001

16 BIRTHPLACE (City) Quebec
(State or country) Quebec Canada

17 NAME OF FATHER James Wilson

18 BIRTHPLACE OF FATHER (City) Quebec
(State or country) Quebec Canada

19 MAIDEN NAME OF MOTHER Julia Farrell

20 BIRTHPLACE OF MOTHER (City) Quebec
(State or country) Quebec Canada21 Informant Ruth Crane
(Address) 1111 Elm St. Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Swann (P)
(Signature of Agent of Board of Health or other)Health Officer October 21, 1963
(Official Designation) (Date of Issue of Permit)

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SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
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RULES OF PRACTICE

OCT 21 1963 PM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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Pronounced dead October 23, 1963
at 5:55 a.m. by Charles
Liberman, M.D. Certificate
signed by John F. Collins, M.D.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 6 Central St.



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 212

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles W. King
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) I. I. I.

(a) Residence. No. 6 Central St.
(Usual place of abode)

St. Winthrop Mass.
(City or town and State)

Length of stay: In place of death 10 years months days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 23, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
19 to 19
I last saw him alive on 19 death is said to
have occurred on the date stated above, at 5:55 a.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Presumably due to Natural Causes

Due To
(b)

Due To
(c)

OTHER Deceased was patient at Vet. Adm.
SIGNIFICANT Hospital, Boston, Mass. from
CONDITIONS 8/27/63 to 10/12/63.

Diagnosis: Pneumonia with Effusion.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) John F. Collins, M.D.

Winthrop (Print or Type Name of Board of Health)

(Address) 27 Pennington St. Date Oct. 23, 1963

Revere, Mass.

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 26, 1963

7 NAME OF FUNERAL DIRECTOR Ernest F. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed 10-24-1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED Divorced
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Anna Merschello
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 45 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation Clerk
(Kind of work done during most of working life)

14 Industry or Business Fruit & Produce

15 Social Security No. 015-05-9135

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

17 NAME OF FATHER James King

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Annie McLean

20 BIRTHPLACE OF MOTHER (City) Canada
(State or country)

21 Informant Helen King

(Address) 6 Central St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lerman (S)
(Signature of Agent of Board of Health or other)
Health Officer (October 24, 1963)
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

X

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE..... Jan 3, 1944

DATE OF DISCHARGE..... December 30, 1945

RANK, RATING Coxswain USNR

ORGANIZATION AND OUTFIT..... NAVY

SERVICE NUMBER..... 9045374

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.Registered No. **213**

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Micheling Sala
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 72 South Avenue St. Pearson Mass.
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death.....years.....months 3 days. In place of residence 21 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 25 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from October 24 1963 to October 25 1963
I last saw her alive on October 25, 1963 death is said to have occurred on the date stated above, at 330 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial InfarctINTERVAL
BETWEEN
ONSET AND
DEATH
3 hrDue To ArteriosclerosisDue To Hypertension

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

(Signed) Rose F. Jannini, M. D.408 Pleasant St
(PRINT OR TYPE SIGNATURE)Winthrop Mass Date October 25 19636 Woodlawn Cemetery, Everett
Place of Burial or Cremation (City or Town)DATE OF BURIAL October 28 19637 NAME OF FUNERAL DIRECTOR Jannini & ClementeADDRESS 221 North Street Boston, MassReceived and filed OCT 25 1963 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 SINGLE (write the word) Widowed
MARRIED WIDOWED or DIVORCED10a If married, widowed, or divorced HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Feodant Sala
(Husband's name in full)11 IF STILLBORN, enter that fact here.
12 AGE 66 Years.....Months.....Days If under 24 hours
Hours.....Minutes13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Italy
(State or country)17 NAME OF FATHER Michelo Glasi18 BIRTHPLACE OF FATHER (City) Italy
(State or country)19 MAIDEN NAME OF MOTHER Francesca Vigliore20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)21 Informant Leresa Basile (Daughter)
(Address) 72 South AveI HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Joseph E. Seranno (13)
(Signature of Agent of Board of Health or other)Heath River October 25, 1963
(Official Designation) (Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



OCT 25 1963 PM

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No. 214

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. BAY VIEW NURSING HOME 26 STURGEON ST.

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME GRACE (HARRIMAN) VAN TYNE

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, NO
(if so specify WAR)

(a) Residence. No. 26 STURGEON ST 49 Beal St. St. WINTHROP

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 3 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 26, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
1-27-53, 19 to 10-26, 1963I last saw him on Oct. 24, 1963 death is said to
have occurred on the date stated above, at 6:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic & hyper-
tensive heart diseaseINTERVAL
BETWEEN
ONSET AND
DEATH
10 yrs

Due To Generalized arteriosclerosis

(b)

12 yrs

Due To

(c)

OTHER SIGNIFICANT CONDITIONS pernicious anemia 10 yrs

Was autopsy performed? no

What test confirmed diagnosis? clinical & lab

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein Jr.

M. Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Wintthrop, Mass. Date 10-28, 1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT 27, 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W. MIRBY
ADDRESS WINTHROP

OCT 28 1963

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED WIDOWED10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)(or) WIFE of DAVID VAN TYNE
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation SECRETARY (RETIRED)
(Kind of work done during most of working life)

14 Industry or Business FARM EQUIPMENT

15 Social Security No. 630-03-1741

16 BIRTHPLACE (City) HAVEMILL
(State or country) MASS

17 NAME OF FATHER HIRAN HARRIMAN

18 BIRTHPLACE OF FATHER (City) CONWAY
(State or country) NH

19 MAIDEN NAME OF MOTHER THERESA BOYLE

20 BIRTHPLACE OF MOTHER (City) PROVIDENCE
(State or country) R.I.21 Informant MRS DOROTHY MIRBY
(Address) TAMPA FLAI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Silianni
(Signature of Agent of Board of Health or other)Health Officer Oct. 28, 1963
(Official Designation) (Date of Issue of Permit)

301A

IONS

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signature.

925686

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



OCT 28 1963 PM



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

Registered No. 215

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

St. } (If death occurred in a hospital or institution,
give its NAME instead of street and number)2 NAME OF FETUS Ford, Baby Boy
(if given)3 DATE OF DELIVERY 10 / 28 / 63
(Month) (Day) (Year)4 SEX Male ☒ Female.....Undetermined.....

5 COLOR (if determined) wh

6 THIS BIRTH (Check one)
Single ☒ Twin.....Triplet.....7 IF MULTIPLE BIRTH, BORN:
1st.....2nd.....3rd.....8 FATHER
FULL NAME Harry T. Ford14 MOTHER
MAIDEN NAME Marilyn A. Marcella
PRESENT NAME Marilyn A. Ford9 RESIDENCE, NO. 72 Wordsworth Street STREET
CITY OR TOWN E. Boston STATE Mass.15 RESIDENCE, NO. 72 Wordsworth St. STREET
CITY OR TOWN E. Boston STATE Mass.

10 COLOR OR RACE wh 11 AGE AT TIME OF THIS DELIVERY 29 (Years)

16 COLOR OR RACE wh 17 AGE AT TIME OF THIS DELIVERY 25 (Years)

12 PLACE OF BIRTH Annapolis Maryland
(City or Town) (State or country)18 PLACE OF BIRTH Boston Mass.
(City or Town) (State or country)

13 OCCUPATION shipwright

19 INFORMANT Harry T. Ford

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus) 2

(a) How many children are now living? 2

(b) How many children were born alive but are now dead? 0

(c) How many previous fetal deaths of ANY gestation age? 0

21 LENGTH OF PREGNANCY completed weeks 28

22 Weight ⁴ Lb. OF FETUS (or) Oz. Grams)

23 WHEN DID FETUS DIE? Before Labor During Labor or Delivery Unknown

24 AUTOPSY Yes No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Intrauterine Death

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 Woodlawn Cemetery Everett Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 29 1963

27 NAME OF FUNERAL DIRECTOR Francis J. Linnecy
ADDRESS 726 Saratoga St E. Boston

Received and filed 10-29 1963

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 7:18 p.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

G. Guy Grande M.D.
(PRINT OR TYPE NAME)Address 20 SARATOGA ST Date 10/29/63
EAST BOSTON MASS

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Linnecy (S)
(Signature of Agent of Board of Health or other)Health Officer
(Official Designation)October 29, 1963
(Date of Issue of Permit)

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

The Commonwealth of Massachusetts

211

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Chelsea

(City or Town)



COPY OF
CERTIFICATE OF DEATH

Registered No. 517 216

No. U.S. Naval Hospital

{(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)}

2 FULL NAME Clarence Hernandez
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR) WWI

(a) Residence. No. 91 Winthrop St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death. years. months. 4 days. In place of residence. 15 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 11, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1963, to Sept. 11, 1963
I last saw him alive on Sept. 11, 1963, death is said to have occurred on the date stated above, at 11:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH

(a) Congestive heart failure

(b) Due To

(c) Due To Arteriosclerotic heart disease

OTHER SIGNIFICANT CONDITIONS Pneumonia

Was autopsy performed? yes

What test confirmed diagnosis? ---

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) John J. Tobin, Jr., M. D.

(Address) USNH, Chelsea, Mass. 9/11/63

6 Winthrop Cem., Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 13, 1963

7 NAME OF FUNERAL DIRECTOR Reynolds Fun. Home

ADDRESS 180 Winthrop St., Winthrop, Mass.

Received and filed NOV 18 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced HUSBAND of Vivian Perdue
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 76 years, 6 months, days If under 24 hours Hours Minutes

13 Usual Occupation: U.S. Army (SPC)
(Kind of work done during most of working life)

14 Industry or Business: U.S. Army

15 Social Security No. 010-22-8477

16 BIRTHPLACE (City) (State or country) Fort Hamilton, N.Y.

17 NAME OF FATHER Joseph A. Hernandez

18 BIRTHPLACE OF FATHER (City) (State or country) Boston, Mass.

19 MAIDEN NAME OF MOTHER Mary Salvo

20 BIRTHPLACE OF MOTHER (City) (State or country) South Carolina

21 Informant Mrs. Vivian Hernandez (wife)

(Address) 91 Winthrop St., Winthrop

MAILED COPY

ATTEST: Joseph A. Tyrrell
(Registrar of City or Town where death occurred)

DATE FILED Sept. 12, 1963

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE..... June 1903

DATE OF DISCHARGE..... Dec. 1929

RANK, RATING..... SFC

ORGANIZATION AND OUTFIT..... U.S. Army

SERVICE NUMBER..... R718714

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

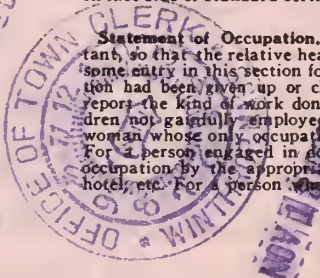
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



FORM R-301

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rd of Health
s Agent.

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FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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2-93404

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



OUT - OF - TOWN

(City or Town making this return)

09687

Registered No.

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Frank St. George
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, NO
if so specify WAR)

(a) Residence, No. 36 Sagamore Avenue
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 5 years 5 months 5 days. In place of residence 10 years 10 months 10 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 22 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
September 17, 63 to September 22, 19, 63
we last saw him alive on September 22, 19, 63, death is said to

have occurred on the date stated above, at 9:45p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of LungINTERVAL
BETWEEN
ONSET AND
DEATH

6 months

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT Carcinoma of Colon
CONDITIONS

Months

Was autopsy performed? YesWhat test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles L. Clay, M.D., M. D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Sept. 22, 63

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 26, 19, 637 NAME OF FUNERAL DIRECTOR Ernest P. CaggianoADDRESS 147 Winthrop St., Winthrop

Received and filed

William J. Kane SEP 30 1963
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widowed

11 If married, widowed or divorced
HUSBAND of Annie E. Tuckley

(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 77 Years 7 Months 7 Days

If under 24 hours
Hours Minutes

13 Usual Occupation: Retired Longshoreman
(Kind of work done during most of working life)

14 Industry or Business: Shipping

15 Social Security No. 030-01-4640

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

17 NAME OF FATHER John St. George

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Rose Maguire

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Mass.

21 Informant Edward St. George
(Address) 6 Revere St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transport permit was issued:

Jacqueline Davis
(Signature of Agent of Board of Health or other)
#B18018 9/25/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



NOV 20 1963 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 534218

PLACE OF DEATH

Suffolk

(County)

Chelsea

(City or Town)

No. Chelsea Memorial Hospital

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Mario Bernatein

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR,

(a) Residence, No. Mounts Rest Home, 104 Highland Ave, Winthrop, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence, 7 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 23, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 23 19. 63, to Sept. 23 19. 63

I last saw him alive on Sept. 23 19. 63 death is said to have occurred on the date stated above, at 6:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH(a) Cerebral vascular
Due To accident

2 hrs.

(b) Esophageal veins

OTHER
SIGNIFICANT
CONDITIONS G.I. Bleeding

Was autopsy performed? yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Benjamin I. Cassin, M. D.

(Address) 117 Wash. Ave., Chelsea, Mass.

6 Chevra Torah, Everett, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Sept. 25, 1963

7 NAME OF FUNERAL DIRECTOR Torf Fun. Service

ADDRESS Washington Ave., Chelsea, Mass.

Received and filed NOV 18 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widowed

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Harris Bernstein

(Husband's name in full)

12

AGE 77 Years, Months, Days

If under 24 hours

Hours, Minutes

13

Usual

Occupation: Housewife

(Kind of work done during most working life)

14

Industry

or Business:

at home

15

Social Security No. none

16

BIRTHPLACE (City)

(State or country)

Paris, France

17

NAME OF

FATHER

Isaac Salacechik

18

BIRTHPLACE OF

FATHER (City)

(State or country)

Russia

19

MAIDEN NAME

OF MOTHER

Paula (cannot be learned)

20

BIRTHPLACE OF

MOTHER (City)

(State or country)

Russia

21

Informant

(Address)

Mrs. Maurico Greenfield

79 Garland St. Chelsea, Mass.

TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

Sept. 24, 1963

19.

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....



OUT - OF - TOWN 219

To be filed for burial
permit with Board of
Health or its agent.

Registered No.

COUNTY

(County)

SUFFOLK

(City or Town)

The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S

CERTIFICATE OF DEATH

No. Peter Bent Brigham Hosp (If death occurred in a hospital or institution, give its NAME instead of street and number)7 FULL NAME Paul Nichols
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No(a) Residence. No. 283 Court Road
(Usual place of abode)St. Ward, Winthrop, MassachusettsLength of residence in city or town where death occurred 63 yrs. mos. days. How long in U. S., if of foreign birth? yrs. mos. 1 days.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR

White

5 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED Married

6 I married, widowed, or divorced

USUALLY of Mary Agnes McDonald
(Give maiden name of wife in full)(or) WIFE of (Husband's name in full)6 Age of husband or wife if alive 63 years

7 IF STILLBORN, enter that fact here:

8 AGE 63 Years 7 Months 18 Days
If less than 1 day 1 hours 0 Minutes9 Usual Occupation: Appraiser10 Industry or Business: Estates11 Social Security No. 021-07-919412 BIRTHPLACE (City) Winthrop
(State or country) Mass.13 NAME OF FATHER Walter E. Nichols14 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass.15 MAIDEN NAME OF MOTHER Amanda P. Harrington16 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Mass.17 I am the mother of Mary R. Nichols (Relationship, if any)
(Address) 283 Court Rd. Winthrop, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death was
filed with me BEFORE the burial of transit permit was issued.Jacqueline
Agent of Board of Health or
1318042 7-63
(Official Designation) (Date of Issue of Certificate)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Sept 25 1963
(Month) (Day) (Year)19 I HEREBY CERTIFY that I have investigated the death of the person
above-named and that the CAUSE AND MANNER thereof are as follows:
(If an injury was involved, state fully.)
Arteriosclerotic Heart Disease20 IN WHAT CITY OR TOWN
WAS INJURY SUSTAINED?(Signed) Seaphile M. D.
(Address) 283 Mass Date 25 196321 CREATION OR REMOVAL Winthrop, Winthrop
(City or town)
DATE OF BURIAL Sept. 28, 196322 NAME OF UNDERTAKER Richard C. Kirby Inc.
ADDRESS 27 Harrington St. E. BostonIf deceased was a U. S. War Veteran, C. L. Chap. 4, Section 16, require physician to insert a recital to that effect
of death. See report to effect. If applicable for the laws relative to the return of certificates of death.

8M-7453-2212

0 1963

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



NOV 20 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 541 220

PLACE OF DEATH

Suffolk

(County)

Chelsea

(City or Town)

No. Soldiers' Home

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

WWII

2 FULL NAME Joseph Edward Amerena

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR,

(a) Residence. No. 37 Floyd

(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death hospital 17 yrs. In place of residence 6 yrs. - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 26, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from Sept. 9, 1963, to Sept. 26, 1963

I last saw him live on Sept. 26, 1963 death is said to have occurred on the date stated above, at 2:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH

(a) Arteriosclerotic heart disease

Due To

(b)

yrs.

(c) Coronary artery insufficiency. Congestive heart failure

Due To

OTHER SIGNIFICANT CONDITIONS

mos.

hrs.

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Richard F. McCarthy, M. D.

(Address) Soldiers' Home Date Sept. 27/63

6 Holy Cross, Malden, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL Sept. 29, 1963

7 NAME OF FUNERAL DIRECTOR DiPietro and Fazza Fun.

ADDRESS 11 Henry St., E. Boston, Mass.

Received and filed NOV 18 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 56 Years 7 Months 20 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Manager-retired

(Kind of work done during most working life)

14 Industry

or Business:

Retail Liquor Store

15 Social Security No.

021-01-3666

16 BIRTHPLACE (City)

(State or country)

Salem, Mass.

17 NAME OF

FATHER

Joseph Amerena

T

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SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE..... 10/3/42.....
DATE OF DISCHARGE..... 10/19/45.....
RANK, RATING..... T4 272 Ord.Main.Co.AAArmy.....
ORGANIZATION AND OUTFIT..... U.S.Army.....
SERVICE NUMBER..... 31208234.....
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RM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

221

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

10324

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)
PHYSICIAN - IMPORTANT

2 FULL NAME Thomas F. Caffrey

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

No

(a) Residence, No. 152 Somerset Avenue
(Usual place of abode)

s. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months 13 days. In place of residence 18 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 10 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
September 24 1963 to October 10 1963

I last saw him live on October 10 1963 death is said to

have occurred on the date stated above, at 10:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ENCEPHALITIS UNKNOWN
ETIOLOGYINTERVAL
BETWEEN
ONSET AND
DEATH

20 DAYS

Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Oct. 10 1963

Winthrop Winthrop

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 14 1963

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St. Winthrop

Received and filed OCT 15 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Married

11 If married, widowed, or divorced

HUSBAND of Emily Laganosino

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE

71 Years 9 Months 15 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Repairman

(Kind of work done during most of working life)

14 Industry

or Business: telephone

15 Social Security No.

021-02-2039-4

16 BIRTHPLACE (City)

(State or country)

MASS

17 NAME OF

FATHER

Unknown

18 BIRTHPLACE OF

FATHER (City)

Unknown

(State or country)

19 MAIDEN NAME

OF MOTHER

Unknown

20 BIRTHPLACE OF

MOTHER (City)

Unknown

(State or country)

21 Informant Mrs. Emily Caffrey

(Address) 152 Somerset Ave, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with the BUREAU the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

T. H. V.

A TRUE COPY ATTEST:

William J. Kane.

RECEIVED



DEC - 21 1963 AM

For burial permit
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2-1963

The Commonwealth of Massachusetts

222

Suffolk

(County)

Boston

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 10268

No. New England Deaconess Hospital

(If death occurred in a hospital or institution,
St. (give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

Listed Mary A.
2 FULL NAME Mrs. Veronica A. Murphy

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, NO
if so specify WAR)

(a) Residence. No. 82 Sargent Street
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 1 years 20 months 20 days. In place of residence 4 years 11 months 11 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 10, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 20, 1963 to October 10, 1963

I last saw ex alive on October 10, 1963, death is said to have occurred on the date stated above, at 11:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC RUPTURE

INTERVAL
BETWEEN
ONSET AND
DEATH

MIN.

Due To (b) MYOCARDIAL INFARCTION

DAYS

Due To (c) CORONARY ARTERIOSCLEROSIS

YEARS

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS
ARTERIOSCLEROSIS OBLITERANS

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Stephen Podolsky M. D.

(Print or Type Name) STEPHEN PODOLSKY

(Address) JOSEPH CLINIC Date OCT. 10, 1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 14, 1963

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed OCT 15 1963

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of John A. Murphy

(Husband's name in full)

12 AGE 62 Years 7 Months 15 Days 11 under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 32-09-1309-3

16 BIRTHPLACE (City) Exeter
(State or country) New Hampshire

17 NAME OF FATHER James Kreiger

18 BIRTHPLACE OF FATHER (City)

(State or country) Germany

19 MAIDEN NAME OF MOTHER Katherine Cooper

20 BIRTHPLACE OF MOTHER (City)

(State or country) Roland

21 Informant John A. Murphy Jr.

(Address) 4 St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



DEC - 2 1963 AM

COPY OF CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

STATE OF NEW HAMPSHIRE

TOWN OR CITY
CLERK'S NO.223
Winthrop
Mass

1. NAME OF DECEASED (TYPE OR PRINT) Edith		A. (FIRST)		B. (MIDDLE)		C. (LAST)		2. DATE OF DEATH		(MONTH) (DAY) (YEAR)			
				Runnels		Quirk		Oct. 13, 1963					
3. PLACE OF DEATH A. COUNTY Belknap						4. USUAL RESIDENCE (WHERE DECEASED LIVED. IF INSTITUTION: RESIDENCE BEFORE ADMISSION.) A. STATE Mass. B. COUNTY							
B. CITY OR TOWN Laconia						C. CITY (GIVE ACTUAL TOWN OF RESIDENCE, NOT MAILING ADDRESS). OR TOWN Winthrop							
D. FULL NAME OF HOSPITAL OR INSTITUTION Laconia Hospital						E. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
D. STREET ADDRESS 64 Lincoln St.													
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. NAME OF HUSBAND OR WIFE (MAIDEN NAME IF WIFE) John J. Quirk							
9. DATE OF BIRTH 9-2-1892		10. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		11A. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) Diatrician		11B. KIND OF BUSINESS OR INDUSTRY Hospital			
12. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) Lakeport, N.H.				13. CITIZEN OF WHAT COUNTRY? U. S. A.				14. FATHER'S NAME William Runnels					
15. MOTHER'S MAIDEN NAME Julia Kinney						16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES OF SERVICE) no		17. SOC. SEC. NO. none					
18A. INFORMANT Mrs. Esther McCullough						18B. ADDRESS 64 Lincoln St., Winthrop, Mass.							
19. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A) Acute coronary occlusion										INTERVAL BETWEEN ONSET AND DEATH 9-10-hrs			
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST. } DUE TO (B) Arteriosclerotic heart disease													
DUE TO (C)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (A)										20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				21B. DESCRIBE HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II OF ITEM 18.)									
21C. TIME OF INJURY MONTH DAY YEAR HOUR MIN. 3:50 a.m.													
21D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21E. PLACE OF INJURY (E. G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)				21F. CITY, TOWN OR LOCATION COUNTY STATE					
22. I attended the deceased from 10-13-63 to 10-13-63 and last saw her xxx alive on 10-13-63 . Death occurred at 3:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.													
23A. SIGNATURE H. E. Trapp, M. D.				(DEGREE OR TITLE)				23B. ADDRESS Laconia, N.H.				23C. DATE SIGNED 10-15-63	
24E. PLACE OF BURIAL				NAME OF CEMETERY				LOCATION (CITY, TOWN, COUNTY) (STATE)				DATE	
25. FUNERAL DIRECTOR'S SIGNATURE E. P. Caggiand, Winthrop, Mass.				ADDRESS				COUNTERSIGNED-AGENT (CITY, ST. OF HEALTH) William L. Gage, MD				DATE 10-13-63	
DATE REC'D BY TOWN OR CITY CLERK Oct. 21st, 1963				CLERK'S OWN SIGNATURE Kenneth R. Dunlap				CLERK OF Laconia, N.H.					

A true copy, Attest: Kenneth R. Dunlap Clerk of Laconia, NH Dated 10-21-1963

A

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NOV 14 1963 AM

The Commonwealth of Massachusetts

224

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 10517

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



No. Boston Lying-In Hospital

{(If death occurred in a hospital or institution,
give its NAME instead of street and number)}2 FULL NAME Robin Ann Holden
Baby Girl Holden

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran,
if so specify WAR.) No

(a) Residence. No. 17 Cliff Avenue St. Winthrop, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 14 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
October 14 1963 to October 14 1963I last saw him alive on October 14 1963 death is said to
have occurred on the date stated above, at 3 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Neonatal Death

(b) Respiratory Arrest

(c) Probable Hyaline Membrane Disease

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes.

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ..
If so, specify ..

(Signature) Theodore Feinstein M. D.

(Print or Type Name)

(Address) 221 Longwood Ave. Date 10/14 1963

6 Holy Cross Cemetery Malden Mass

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL October 18 1963

7 NAME OF FUNERAL DIRECTOR William J. Killion

ADDRESS 1 Sprague St. Revere, Mass.

Received and filed ..

OCT 22 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

F

W

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Single

11 If married, widowed, or divorced

HUSBAND of ..
(Give maiden name of wife in full)(or) WIFE of ..
(Husband's name in full)

12

AGE.....Years.....Months.....Days

If under 24 hours

11 Hours 46 Minutes

13 Usual

Occupation: ..

(Kind of work done during most working life)

14 Industry

or Business: ..

15 Social Security No. none

16 BIRTHPLACE (City) Boston, Mass.

(State or country)

17 NAME OF FATHER Dudley Holden

18 BIRTHPLACE OF FATHER (City)

Malden, Mass.

(State or country)

19 MAIDEN NAME OF MOTHER

Barbara Connolly

20 BIRTHPLACE OF MOTHER (City)

Tewkesbury, Mass.

(State or country)

21 Informant

(Address)

Boston Lying-In Hospital

221 Longwood Ave.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

18397

(Official Designation)

10/18/63

(Date of Issue of Permit)

A TRUE COPY ATTEST:

10107
Anthony J. Kane
City Registrar

RECEIVED



DEC 4 1963 AM

burial permit
of Health
Agent.

See also Chap. 36, § 6, 20; Chap. 46, § 9, 10; Chap. 114, § 44-48. If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

420
81
X 70

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

10458

En route to East Boston Relief Station

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME **SARAH** **LOURIE**
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a
U. S. War Veteran,
(if so specify WAR) **NO**

(a) Residence. No. **85 Sagamore Avenue,** St. **Winthrop, Massachusetts**
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **October 14, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death
of the person above-named and that the CAUSE AND MANNER thereof
are as follows: (If an injury was involved, state fully.)
**Hypertensive and arteriosclerotic
heart disease.**

5 Accident, suicide, or homicide (specify).....

Date and hour of injury19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did
Injury occur?
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in
public place?
(Specify type of place)

Manner of
Injury
(How did injury occur?)

Nature of
Injury
While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) **Michael A. Luongo, M.D.**

(Print or Type Name)

(Address) **Boston** Date **10/15 1963**

WINTHROP CEMETERY **EVERETT**
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL **October 16, 1963**

8 NAME OF FUNERAL DIRECTOR **ARNOLD Galov**
ADDRESS **1668 BEACON ST. BROOKLINE**

Received and filed **OCT 17 1963** 19.....
William J. [Signature]

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX **FEMALE** 10 COLOR **White** 11 SINGLE (write the word)
MARRIED
WIDOWED **Single**
DIVORCED
UNKNOWN

12 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

13 AGE **69** Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

14 Usual Occupation: **BOOKKEEPER**
(Kind of work done during most of working life)

15 Industry or Business: **Columbia Pictures**

16 Social Security No.

17 BIRTHPLACE (City) **Boston**
(State or country)

18 NAME OF FATHER **MOSES LOURIE**

19 BIRTHPLACE OF FATHER (City) **RUSSIA**
(State or country)

20 MAIDEN NAME OF MOTHER **LENA BAND**

21 BIRTHPLACE OF MOTHER (City) **RUSSIA**
(State or country)

22 Informant (Address) **Lillian Sagan (Sister)**
85 Sagamore Ave, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

R. J. Rogerson
(Signature of Agent of Board of Health or other)

B18332
(Official Designation)

10-16-63
(Date of Issue of Permit)

V.A. ✓

A TRUE COPY ATTEST:

William J. Kane
City Register

RECEIVED



DEC - 21 1963 AM

For burial permit
and of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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(b) and (c)

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heart failure,
etc. It means
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death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

PLACE OF DEATH

SUFFOLK
(County)ROXBURY
(City or Town)

No. JEWISH MEMORIAL HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME BELLA KLEIN
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WARI)(a) Residence. No. 119 SEWALL ST. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 11 months 11 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 18 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
11-7-1963 to 10-18-1963

I last saw her live on 10-18-1963 death is said to

have occurred on the date stated above, at 7:59 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) STATUS EPILEPTICUS

INTERVAL
BETWEEN
ONSET AND
DEATH

HOURS

(b) CEREBRAL ARTERIOSCLEROSIS

YEARS

(c)

OTHER SIGNIFICANT CONDITIONS

GENERALIZED ARTERIOSCLEROSIS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Samuel Hassid, M. D.

(Address) 100 Main St. Wintthrop

Place of Burial or Cremation

DATE OF BURIAL Oct 20 1963

7 NAME OF FUNERAL DIRECTOR

ADDRESS Chelsea

Received and filed

OCT 22 1963

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Harry Klein (Husband's name in full)

12 AGE 81 Years - Months - Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Retail Store

15 Social Security No. none

16 BIRTHPLACE (City or country) Russia

17 NAME OF FATHER Hyman Mendel Glass

18 BIRTHPLACE OF FATHER (City or country) Russia

19 MAIDEN NAME OF MOTHER Mary Carp

20 BIRTHPLACE OF MOTHER (City or country) Russia

21 Informant Mrs. Rose Pearlstein

(Address) 119 Sewall St. Wintthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J.P. Araca B 10509

(Signature of Agent of Board of Health or other)

OCT 20 1963

(Date of Issue of Permit)

1-1963

William J. Kane
City Register

RECEIVED



DEC - 4 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT OF TOWN
(City or Town making this return)

FORM R-301

For burial permit
of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
CAUSES
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heart failure,
etc. It means
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4 - 1963

PLACE OF DEATH

Suffolk
(County)

Boston
(City or Town)

No. New England Deaconess Hospital



STANDARD
CERTIFICATE OF DEATH

Registered No. 10619

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME Mr. Julius Maged
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 33 Nevada St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death. years. months. 2 days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 19 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
October 17, 1963, to October 19, 1963.

I last saw him alive on October 19, 1963, death is said to
have occurred on the date stated above, at 8:40 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) carcinoma of esophagus

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes
What test confirmed diagnosis? X-rays

5 Was disease or injury in any way related to occupation of deceased No.
If so, specify

(Signature) *Ronald J. Knudsen*, M. D.

(Address) 35 Francis St. Boston
(Print or Type Name)

Date Oct 19, 1963

6 *Wickman Circle, Melrose*
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT 21 1963

7 NAME OF FUNERAL DIRECTOR *Day Funeral Service*

ADDRESS *Chelsea*

Signature and Date *Stefan J. Kase* OCT 23 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 MARRIAGE (write the word)
MARRIED Widowed
DIVORCED
UNKNOWN

11 If married, widowed or divorced
HUSBAND of *Martha Westerman*
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 84 Years Months Days 11 under 24 hours
Hours Minutes

13 Usual Occupation *Sailor*
(Kind of work done during most of working life)

14 Industry or Business *Sailing*

15 Social Security No. *021-28-2884*

16 BIRTHPLACE (City) *Russia*
(State or country)

17 NAME OF FATHER *Benjamin Maged*

18 BIRTHPLACE OF FATHER (City) *Russia*
(State or country)

19 MAIDEN NAME OF MOTHER *(C. A. I.)*

20 BIRTHPLACE OF MOTHER (City) *Russia*
(State or country)

21 Informant *Leo Miller*
33 Nevada St Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

18401 10/21/63

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

ATTEST:

William J. Kane.
City Registrar

RECEIVED



DEC 4 1963 AM

for burial permit
ard of Health
ts Agent.

INSTRUCTIONS
FOR
CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 10819

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No.

BETH ISRAEL HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME CHRISTOPHER ALEXANDER

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) 20

(a) Residence. No. 155

PLEASANT

St. WINTHROP, MASS.

(Usual place of abode)

(City or town and State)

Length of stay: In place of death years months 8 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 10 23 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from 10/20 1963 to 10/23 1963

I last saw him live on 10/23 1963 death is said to have occurred on the date stated above, at 00:30 AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC ARREST

(b) Due To 7 MASSIVE PULM. EMBOLISM } minutes

(c) Due To 7 MYOC. INFARCT

OTHER SIGNIFICANT CONDITIONS St. post hip arthroplasty 4 days

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) R. H. A. M. D.

(Print or Type Name)

(Address) R. H. A. D. 19

6 WINTHROP CEMETERY WINTHROP

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 25 1963

7 NAME OF FUNERAL DIRECTOR MAURIS + MAURIS

ADDRESS 48 So. Common St. Lynn

Received and filed OCT 29 1963

A TRUE COPY ATTEST:

William J.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED

11 If married, widowed, or divorced HUSBAND of DESPINA ARHONDY (ALEXANDER)

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 45 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation CHEF - RESTAURANT (Kind of work done during most of working life)

14 Industry or Business Food

15 Social Security No. 021-01-5363

16 BIRTHPLACE (City) HARTFORD, Conn. (State or country)

17 NAME OF FATHER MICHAEL ALEXANDER

18 BIRTHPLACE OF FATHER (City) THESSINIA GREECE (State or country)

19 MAIDEN NAME OF MOTHER EVA (Unknown)

20 BIRTHPLACE OF MOTHER (City) THESSINIA, GREECE (State or country)

21 Informant MRS. DESPINA ALEXANDER

(Address) 155 PLEASANT ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

B 12489 10-25-63

(Official Designation) (Date of Issue of Permit)

V.B. V

A TRUE COPY ATTEST:

William J. Kane

RECEIVED



DEC 4 1963 AM

for burial permit
ard of Health
s Agent.

INSTRUCTIONS
FOR
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W.C.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 229

Suffolk
(County)

Winthrop
(City or Town)

No. 125 Washington Avenue

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME Wilbur Herbert Freeman
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.

(a) Residence. No. 125 Washington Avenue
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 11 years months days. In place of residence 11 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 3 1963
(Month) (Day) (Year)

4. I HEREBY CERTIFY, That I attended deceased from
DEC 29, 1961, to Nov 3, 1963
I last saw him live on Nov. 2, 1963 death is said to
have occurred on the date stated above, at 9:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GLIOMA

Due To

(b)

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

HYPERTENSION & HYPERTENSIVE HEART DIS

INTERVAL
BETWEEN
ONSET AND
DEATH
8 MO

Was autopsy performed? YES OF HEAD

What test confirmed diagnosis? AUTOPSY

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Myron N. King M.D.

(Address) 111 CLEMENT ST. Date 11/4 1963

6 Winthrop Cemetery Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 5, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed NOV 4 - 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed or divorced HUSBAND of Margaret Dawson
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 69 Years 5 Months 29 Days If under 24 hours
Hours Minutes

13 Usual Occupation retired auditor
(Kind of work done during most working life)

14 Industry or Business First National Bank

15 Social Security No. 031-09-2401

16 BIRTHPLACE (City) Dorchester
(State or country) Massachusetts

17 NAME OF FATHER Edward Farster Freeman

18 BIRTHPLACE OF FATHER (City) Caledonia
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Flora Annie Wheelock

20 BIRTHPLACE OF MOTHER (City) Torbrook
(State or country) Nova Scotia

Mrs. Wilbur H. Freeman

21 Informant 125 Washington Ave. Winthrop
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siranni (H.S.)
(Signature of Agent of Board of Health or other)

Health Officer Nov. 4, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 230

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.Suffolk
(County)Winthrop
(City or Town)

No. 76 Lowell Road

2 FULL NAME John Merton Wilder
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence No. 76 Lowell Road
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 36 years.....months.....days. In place of residence 36 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 8 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan 23, 1963, to Oct 30, 1963

Last saw him live on Oct 30, 1963, death is said to

have occurred on the date stated above, at 7:30 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

Due To (b) arteriosclerotic heart disease yrs

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Congestive heart failure - severe

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) H.B. Greenfield, M. D.

447 Shingle (Printer Type Name)
(Address) Winthrop Mass. Date 11-9 19636 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 12, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed NOV 12 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
DIVORCED
UNKNOWN11 If married, widowed or divorced
HUSBAND of Ethel Margaret Edwards
(Give maiden name of wife in full)(or) WIFE of.....
(Husband's name in full)12 AGE 82 Years 2 Months 26 Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: retired traffic manager
(Kind of work done during most working life)

14 Industry or Business: wholesale wool sales

15 Social Security No. 023-03-9002

16 BIRTHPLACE (City) Chelsea
(State or country) Massachusetts

17 NAME OF FATHER Abbott Aidan Wilder

18 BIRTHPLACE OF FATHER (City) Vermont
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Alexander

20 BIRTHPLACE OF MOTHER (City) Chelsea
(State or country) Massachusetts21 Informant Mrs. John I. Wilder
(Address)

76 Lowell Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Joseph B. [Signature]
(Signature of Agent of Board of Health or other)Health Officer 11-16-1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

T.V. 13-14

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING 2nd Lt. 50

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice.

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 231

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO2 FULL NAME JOHN MARMINO
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 85 QUINCY AVE St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death, years, months, days. In place of residence, 50 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. 10. 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
, 19, to, 19.I last saw him alive on , 19, death is said to
have occurred on the date stated above, at 4:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH(a) Death presumably due
to natural causes,(b) Due To probably acute coronary
(c) occlusion on basis of
history. Wintthrop Board of HealthOTHER SIGNIFICANT CONDITIONS
Charles LibermanWas autopsy performed? Charles Liberman
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MAS Date 11/12/1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV 13 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W HIRBY

ADDRESS WINTHROP.

Received and filed NOV 12 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

MALE WHITE MARRIED (write the word)

11 If married, widowed, or divorced
HUSBAND of DOMENICA PINO
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 79 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: WAITER (RETIRED)
(Kind of work done during most of working life)

14 Industry or Business: RESTAURANT

15 Social Security No. 010-09-3245-A

16 BIRTHPLACE (City)... ITALY
(State or country)

17 NAME OF FATHER STEFANO MARMINO

18 BIRTHPLACE OF FATHER (City)... ITALY
(State or country)

19 MAIDEN NAME OF MOTHER CATERINA BATTAGLIA

20 BIRTHPLACE OF MOTHER (City)... ITALY
(State or country)

21 Informant MRS PAULINE FALCO

(Address) 123 QUINCY AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the funeral, or transit permit was issued:Ralph E. Liriano (P)
(Signature of Agent of Board of Health or other)
Health Officer November 12 '63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RECEIVED

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease, antedated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931c73

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Hingham
(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 232

PLACE OF DEATH

Plymouth
(County)

Hingham
(City or Town)

No. 1192 Main Street

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME Edward Patrick White
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR, No.

(a) Residence, No. 72 Sargent
(Usual place of abode)

St. Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death, 2 years, - months, - days. In place of residence, 45 years, - months, - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 12, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
June 56, to Nov. 12, 1963.
I last saw him alive on Nov. 12, 1963. Death is said to
have occurred on the date stated above, at 7:15 p.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Vascular Accident

Due To Hypertension

Due To Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS Coronary Heart Disease

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Donald M. Garland, M. D.

(Address) Hingham, Mass. Date 11/12/63

6 St. Pauls Arlington, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 15, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed NOV 18 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Widowed

11 If married, widowed, or divorced
HUSBAND of Susanna Harrington White
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 86 years, - Months, - Days
If under 24 hours
Hours Minutes

13 Usual Occupation Retired Dentist
(Kind of work done during most working life)

14 Industry or Business Dentist

15 Social Security No. - -

16 BIRTHPLACE (City) Cambridge, Mass.
(State or country)

17 NAME OF FATHER Edward P. White

18 BIRTHPLACE OF FATHER (City) London
(State or country) England

19 MAIDEN NAME OF MOTHER Catherine Dollard

20 BIRTHPLACE OF MOTHER (City) Currick on Sur
(State or country) Ireland

21 Informant William Russell
(Address) 681 Main Street
Hingham, Mass.

A TRUE COPY

ATTEST: William L. Howard
(Registrar of City or Town where death occurred)

DATE FILED November 14, 1963

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No. 233

PLACE OF DEATH

SUFFOLK
(County)WINTHROP
(City or Town)

No. 52 UPLAND RD.

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. PIO F. MARRUCHELLI
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) NO(a) Residence. No. 52 UPLAND RD
(Usual place of abode)St. WINTHROP
(If nonresident, give city or town and State)

Length of stay: In place of death 40 years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 13 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
JAN 9 1963 to NOV 13 1963I last saw him live on NOV 13 1963, death is said to
have occurred on the date stated above, at 9:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL
BETWEEN
ONSET AND
DEATH(a) UNDIFFERENTIATED
CARCINOMA OF MAXILLA 3 MODue To METASTASIS TO BRAIN
(b) CHEST 6 WKSDue To
(c)OTHER
SIGNIFICANT
CONDITIONS DIABETES MELLITUS 4 WKS

Was autopsy performed? No.

What test confirmed diagnosis? BIOPSY AT PRATT
HOSP5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Myron D. King, M.D.

MYRON D. KING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 120 PLEASANT ST. WINTHROP MASS. Date NOV 14 1963

6 WINTHROP WINTHROP
Place of Burial or Cremation
DATE OF BURIAL NOV 14 19637 NAME OF
FUNERAL DIRECTOR MAURILE W. KIRBY
ADDRESS WINTHROP

Received and filed NOV 15 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED MARRIED10a If married, widowed, or divorced
HUSBAND of MARIA N. LALLI
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years.....Months.....Days If under 24 hours
.....Hours.....Minutes13 Usual Occupation: CLOTHING DESIGNER
(Kind of work done during most of working life)

14 Industry or Business: MEN'S CLOTHING

15 Social Security No.

16 BIRTHPLACE (City) ITALY
(State or country)

17 NAME OF FATHER RALFAELE MARRUCHELLI

18 BIRTHPLACE OF FATHER (City)
(State or country) ITALY

19 MAIDEN NAME OF MOTHER VINCENTA DE SERNIA

20 BIRTHPLACE OF MOTHER (City)
(State or country) ITALY21 Informant MARIA MARRUCHELLI
(Address) 52 UPLAND RD WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer November 15, 1963
(Official Designation) (Date of Issue of Permit)

T V.B.V.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



NOV 15 1963 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important; so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATH

Registered No.

234

No. Sturgis St. Bay View Nursing Home (If death occurred in a hospital or institution,
its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John E. Conway
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, No
if so specify WAR)(a) Residence, No. 44 Belcher St. St. _____
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death 1 years 1 months 1 days. In place of residence 20 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 15 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Oct 19 62 to Nov 15 63
I last saw him live on 11/15/63, 19 63, death is said to
have occurred on the date stated above, at 1:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia, bilateralINTERVAL
BETWEEN
ONSET AND
DEATH
1wk.Due To
(b) _____Due To
(c) _____OTHER SIGNIFICANT CONDITIONS
Cerebral Arteriosclerosis 5 yrs.
Cerebrovascular Thrombosis 6 mos.Was autopsy performed? No
What test confirmed diagnosis? clinical5 Was disease or injury in any way related to occupation of deceased No
If so, specify _____(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)(Address) Winthrop, Mass Date 11/15/636 St. Joseph's West Roxbury
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 18, 19 637 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
Winthrop, Mass
ADDRESSReceived and filed NOV 18 1963 19 _____

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED Married10a If married, widowed or divorced
HUSBAND of Anastasia Butler
(Give maiden name of wife in full)(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 0 Months 0 Days If under 24 hours
Hours 0 Minutes13 Usual Occupation: Retired P.O. Clerk
(Kind of work done during most of working life)14 Industry or Business: U.S. Postal Service15 Social Security No. None16 BIRTHPLACE (City) Tyrone
(State or country) Ireland17 NAME OF FATHER Edward Conway18 BIRTHPLACE OF FATHER (City) Tyrone
(State or country) Ireland19 MAIDEN NAME OF MOTHER Catherine Cullinin20 BIRTHPLACE OF MOTHER (City) Tyrone
(State or country) Ireland21 Informant Anastasia Conway
(Address) 44 Belcher St. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Liberman (P.)
(Signature of Agent of Board of Health or other)Health Officer November 18 1963
(Official Designation) (Date of Issue of Permit)

T W.B.V

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

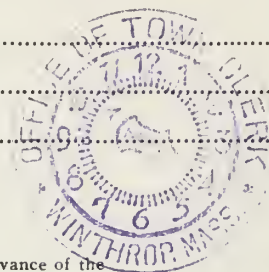
DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease related to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

STANDARD CERTIFICATE OF DEATH

Registered No. 235

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME DeCOURCEY, Baby Girl
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 115 Summit Ave, Winthrop
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 15, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Nov. 15, 1963, to Nov. 15, 1963
I last saw her live on 11/15/63, death is said to
have occurred on the date stated above, at 12:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PREMATUREITY - 5mo 24hrs

Due To PLACENTA ABRUPTIO - 12hrs
(b) PARTIAL

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Myron H. King, M. D.

MYRON H. KING M.D.
(Print or Type Name)

(Address) 22 PLEASANT ST WINTHROP Date Nov. 15, 1963

6 WINTHROP CEMETERY
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOVEMBER 15, 1963

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc
917 BENDINGTON ST. EAST BOSTON
ADDRESS

Received and filed NOV 15 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR W 10 SINGLE (write the word)
MARRIED WIDOWED SINGLE
DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE. Years. Months. Days If under 24 hours
1 Hours 15 Minutes

13 Usual Occupation: (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) WINTHROP, MASS.
(State or country)

17 NAME OF FATHER Richard D DeCourcey

18 BIRTHPLACE OF FATHER (City) WINTHROP, MASS.
(State or country)

19 MAIDEN NAME OF MOTHER JEANNE A. VIENNEAU

20 BIRTHPLACE OF MOTHER (City) WORCESTER, MASS.
(State or country)

21 Informant Richard D. DeCourcey
(Address) 115 Summit Ave, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Seranno (a)
(Signature of Agent of Board of Health or other)

Deputy Officer November 15, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



NOV 15 196



The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with
Board of Health or its Agent.

Registered No. 236

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

St. }

(If death occurred in a hospital or institution,
give its NAME instead of street and number)2 NAME OF FETUS PEARCE, MALE
(if given)3 DATE OF DELIVERY 11/15/63
(Month) (Day) (Year)4 SEX X
Male Female Undetermined

5 COLOR (if determined) W

6 THIS BIRTH (Check one)
Single ☒ Twin ☐ Triplet ☐7 IF MULTIPLE BIRTH, BORN:
1st. 2nd. 3rd.

FATHER

8 FULL NAME ROLAND PEARCE

9 RESIDENCE, NO. 93 CLIFF AVE STREET
CITY OR TOWN WINTHROP STATE MASS

10 COLOR OR RACE WHITE 11 AGE AT TIME OF THIS DELIVERY 26 (Years)

12 PLACE OF BIRTH WINTHROP MASS
(City or Town) (State or country)

13 OCCUPATION MEDICAL INSPECTOR

MOTHER

14 MAIDEN NAME MARGARET F CROWLEY
PRESENT NAME MARGARET F PEARCE15 RESIDENCE, NO. 93 CLIFF AVE STREET
CITY OR TOWN WINTHROP STATE MASS

16 COLOR OR RACE WHITE 17 AGE AT TIME OF THIS DELIVERY 25 (Years)

18 PLACE OF BIRTH SOMERVILLE MASS
(City or Town) (State or country)

19 INFORMANT ROLAND PEARCE

20 PREVIOUS DELIVERIES TO MOTHER
(Do not include this fetus) none

(a) How many children are now living? none

(b) How many children were born alive but are now dead? none

(c) How many previous fetal deaths of ANY gestation age? 1

21 LENGTH OF PREGNANCY completed weeks 36

22 Weight 6 Lb. 14 Oz.
OF FETUS (or Grams)23 WHEN DID FETUS DIE?
Before Labor ☐ (During Labor ☒ or Delivery ☐ Unknown ☐24 AUTOPSY
Yes ☐ No ☐

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Umbilical cord around

Due To (b) baby's neck

Due To (c)

OTHER SIGNIFICANT CONDITIONS none

26 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV 18 1963

27 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed

NOV 18 1963

19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 10:05 A.M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Joseph Gregorie M.D.

Joseph GREGORIE
(PRINT OR TYPE NAME)Address 194 Washington Ave Date 11/15/63
Wintthrop

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Paeph E. Sreann (s)
(Signature of Agent of Board of Health or other)Health officer Nov 18, 1963
(Official Designation) (Date of Issue of Permit)

RECEIVED

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48,
ACTS OF 1960.

Section 2A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

Section 9A. When a child is born dead, after a period of gestation less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 232

No. WINTHROP COMMUNITY HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Pappas
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) 760

(a) Residence, No. 42 Franklin Street St. Winthrop Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 29 years 2 months 29 days. In place of residence 2 years 2 months 29 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov 16 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Aug 1962 to Nov 16 1963
I last saw him live on Nov 16 1963 death is said to have occurred on the date stated above, at 7:35 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Lung 15 mos

(b) Metastatic Cancer of

(c) Esophagus and right lung 1 yr.

OTHER SIGNIFICANT CONDITIONS From primary in left lung left Pneumectomy 1 yr.

Was autopsy performed? Clinical, operative, pathology

What test confirmed diagnosis

5 Was disease or injury in any way related to occupation of deceased? No

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)

(Address) WINTHROP, MASS. Date 11/16/1963

6 WINTHROP CEMETERY WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 19 1963

7 NAME OF FUNERAL DIRECTOR MAURIST MAURIS
Christy S. Mauris

ADDRESS 48 So. Common St. Lynn

Received and filed NOV 19 1963

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR White 10 SINGLE (write the word) MARRIED Married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed or divorced HUSBAND of PAGONA SAGOULAS PAPPAS
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 70 Years - Months - Days If under 24 hours Hours - Minutes

13 Usual Occupation RESTAURANT PROP.
(Kind of work done during most working life)

14 Industry or Business Food

15 Social Security No. 217-28-0025

16 BIRTHPLACE (City) (State or country) Messinia GREECE

17 NAME OF FATHER GEORGE PAPPAS

18 BIRTHPLACE OF FATHER (City) (State or country) Messinia GREECE

19 MAIDEN NAME OF MOTHER KATERINA STAVRIANIA

20 BIRTHPLACE OF MOTHER (City) (State or country) Messinia GREECE

21 Informant (Address) MRS PAGONA PAPPAS (wife)
42 FRANKLIN ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) November 19 1963

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

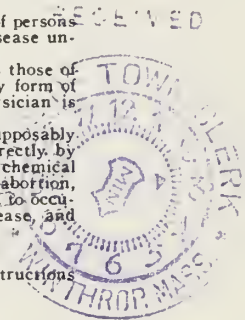
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

2 FULL NAME

Pasquale Graziose

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No.

4 Billerica Street

(Usual place of abode)

St.

Boston

(City or town and State)

Length of stay: In place of death years 3 months days. In place of residence 25 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

November 17, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Sept 24, 1963, to Nov. 17, 1963

I last saw him alive on Nov. 12, 1963 death is said to have occurred on the date stated above, at 9:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

(b) Due To

(c) Due To

(d) Due To

(e) Due To

OTHER SIGNIFICANT CONDITIONS

Pulmonary Fibrosis -

Was autopsy performed?

No

What test confirmed diagnosis?

Clinical

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

No

(Signature)

Charles J. Ferreri, M.D.

(Print or Type Name)

154 Bennington St., E. Boston 11/18 1963

6

St. Michael Cemetery

Boston

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Nov. 20,

1963

7 NAME OF FUNERAL DIRECTOR

Vincent R. Rapino

9 Chelsea St., East Boston, Mass.

ADDRESS

Received and filed

NOV 19 1963

19

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

238

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR)

no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

white

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

divorced

11 If married, widowed, or divorced

HUSBAND of

Ester Calo

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE

78

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual Occupation

Retired

(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No.

017-14-5431

16 BIRTHPLACE (City)

(State or country)

Italy

17 NAME OF FATHER

FATHER

Eugene Graziose

18 BIRTHPLACE OF FATHER (City)

(State or country)

Italy

19 MAIDEN NAME OF MOTHER

OF MOTHER

Maria (unknown)

20 BIRTHPLACE OF MOTHER (City)

(State or country)

Italy

21 Informant

Eugene Graziose (son)

(Address)

4 Sycamore Circle, W. Peabody, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul G. Sweeney (S)

(Signature of Agent of Board of Health or other)

Health Officer

November 19, 1963

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

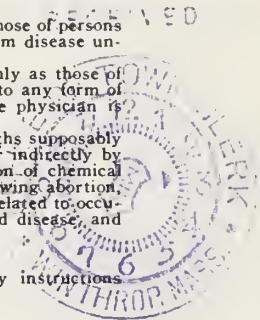
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



APR 19 1963 PM

RM R-301

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Withrop

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. 239

No. ~~XXXXXX~~ Amos W. Crooks Win.Com. Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Amos W. Crooks
(If deceased is a married, widowed or divorced woman, give also maiden name.)
34 Thornton Park
Winthrop Community Hospital
PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. ~~XXXXXX~~ (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 5 years, months, 12 days. In place of residence 55 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 20 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 6 1960, to Nov. 20 1963
I last saw him alive on Nov. 19 1963 death is said to have occurred on the date stated above, at 6:10 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized carcinomatosis
1 yr.

Due To (b) Carcinoma of Prostate
3 1/2 yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? None
What test confirmed diagnosis? Clin. & Lab.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Maurice Traunstein, Jr., M.D.
Maurice Traunstein, Jr., M.D.
(Print or Type Name)

(Address) 73 Bartlett Rd. Date Nov. 20 1963
Winthrop, Mass.

6 Woodlawn Creamatory Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 22, 1963

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed NOV 22 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Grace Caroline Ford
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 73 Years 9 Months 6 Days If under 24 hours Hours Minutes

13 Usual Occupation: Engineer
(Kind of work done during most working life)

14 Industry or Business: Air Conditioning Co.

15 Social Security No. 012-01-4537

16 BIRTHPLACE (City) Malone (State or country) New York

17 NAME OF FATHER Warren Crooks

18 BIRTHPLACE OF FATHER (City) Philadelphia (State or country)

19 MAIDEN NAME OF MOTHER Helen Willard

20 BIRTHPLACE OF MOTHER (City) Malone (State or country) New York

21 Informant Mrs. Amos W. Crooks (Address)

34 Thornton Park, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Serrano (Signature of Agent of Board of Health or other) Nov. 22, 1963
Health Officer (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

T VJB

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 240

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)

No. 23 THORNTON PARK

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME HELEN W. (Winston) Keough
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) NC

(a) Residence. No. 23 THORNTON PARK
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death 56 years 16 months 56 days. In place of residence 56 years 16 months 56 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 29 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Nov 27, 1963, to Nov 29, 1963

I last saw her alive on Nov 27, 1963, death is said to
have occurred on the date stated above, at 7:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arterio sclerotic Heart Disease

Due To Arteriosclerosis

Due To

OTHER
SIGNIFICANT
CONDITIONS None

Was autopsy performed? NO

What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) John F. Collins MD, M. D.

(Print or Type Name)

(Address) 23 Bennington St. Date 30 Nov 1963
Revere Mass

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 2 1963

7 NAME OF FUNERAL DIRECTOR MORRICE W. HARRY

ADDRESS WINTHROP

Received and filed DEC 2 - 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN WIDOWED

11 If married, widowed, or divorced
HUSBAND of

(or) WIFE of EDWARD J. KEOUGH
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 80 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation HOME MAINTENANCE
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

17 NAME OF FATHER MICHAEL WINSTON

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER MARY MITCHELL

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant EDWARD W. KEOUGH WINTHROP
(Address) 23 THORNTON PARK

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sweeney (Signature of Agent of Board of Health or other)
Health Officer (Official Designation) Dec 2 1963 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 241

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)

No. 6 Grandview Ave

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Fannie I. Lang
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran,
if so specify WAR) no(a) Residence, No. 6 Grandview Ave
(Usual place of abode)St. Winthrop, Mass.
(City or town and State)

Length of stay: In place of death - years 7 months - days. In place of residence 45 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 29, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from
August 15, 63, to Nov. 29, 63I last saw him alive on Nov. 27, 1963, death is said to
have occurred on the date stated above, at 1:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) generalized carcinomatosis

INTERVAL
BETWEEN
ONSET AND
DEATH(b) Due To adenocarcinoma of the
rectum

(c) Due To none

OTHER
SIGNIFICANT
CONDITIONS noneWas autopsy performed? no
What test confirmed diagnosis? Clinical & laboratory5 Was disease or injury in any way related to occupation of deceased? no
If so, specify(Signature) Maurice Traunstein, Jr., M.D.
(Print or Type Name)(Address) 73 Bartlett Rd., Nov. 29, 63
Winthrop Mass. 021526 Lebanon Lodge Peabody
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 1, 1963

7 NAME OF FUNERAL DIRECTOR Joy Funeral Service Inc.

ADDRESS Chelsea

Received and filed NOV 29 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Clarence E. Lang
(Husband's name in full)12 AGE 62 Years - Months - Days If under 24 hours
Hours - Minutes13 Usual Occupation Proprietor
(Kind of work done during most of working life)

14 Industry or Business Gown Shop

15 Social Security No. 031-14-5759

16 BIRTHPLACE (City) Russia
(State or country)

17 NAME OF FATHER (C.B.L.) Iskowitz

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER C.B.L.

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)21 Informant John Asquith
(Address) 6 Grandview Ave WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seranno (B)

(Signature of Agent of Board of Health or other)

Health Officer

November 29, 1963
(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

NOV 29 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. 11 Bartlett Parkway

2 FULL NAME Christopher C. Nugent
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 11 Bartlett Parkway
(Usual place of abode)

Length of stay: In place of death, years, months, days. In place of residence, 50 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 30, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Nov. 6, 1963, to Nov. 30, 1963

I last saw him live on Nov. 27, 1963, death is said to
have occurred on the date stated above, at 1:35 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease 1 yr.

Due To (b) Arteriosclerosis, generalized 5 yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no

What test confirmed diagnosis? clinical findings

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) John F. Collins, M.D.

(Print or Type Name)

(Address) 27 Pennington St. Date 12/2/63

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 3, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed DEC 2 - 1963

(Registrar)

A TRUE COPY ATTEST:



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 242

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED Widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Mary Dempsey
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 85 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation Proprietor
(Kind of work done during most working life)

14 Industry or Business Motor Transportation

15 Social Security No.

16 BIRTHPLACE (City) Newark New Jersey
(State or country)

17 NAME OF FATHER John Nugent

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary J. Pilkington

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant John Nugent
(Address) 11 Bartlett Parkway, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Lironne (s)
(Signature of Agent of Board of Health or other)

Health Officer December 2, 1963
(Official Designation) (Date of Issue of Permit)

T V.A. ✓

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease not related to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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RECEIVED

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)



The Commonwealth of Massachusetts

 KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF
CERTIFICATE OF DEATH

Registered No. 243

 No. Danvers State Hospital Danvers (If death occurred in a hospital or institution, give its NAME instead of street and number)

 2 FULL NAME Florence G. Teel (If deceased is a married, widowed or divorced woman, give also maiden name.)
 (Was deceased a U. S. War Veteran, if so specify WAR, no)

 (a) Residence. No. 15 Sturgis St. Winthrop Mass. St. (If nonresident, give city or town and State)
 (Usual place of abode)

 Length of stay: In place of death 11 years 1 months 2 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH August 30, 1963
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY That I attended deceased from April 30, 1961, to August 30, 1963.
 I last saw him on August 30, 1963, at 8:30 a.m. Death is said to have occurred on the date stated above, at 8:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gastroenteritis - Acute
 (b) Mechanical Obstruction of duodenum
 (c) months

 OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Dis.
Gen. Arteriosclerosis yrs.

 Was autopsy performed? no
 What test confirmed diagnosis? Clin. & Lab.

 5 Was disease or injury in any way related to occupation of deceased?
 If so, specify

 (Signed) Willard M. Hausman
Willard M. Hausman M. D.

 (Address) Hathorne, Mass. Date 8/30/1963

 6 Mt. Auburn Cemetery, Cambridge,
 Place of Burial or Cremation (City or Town)

 DATE OF BURIAL Sept. 3, 1963

 7 NAME OF FUNERAL DIRECTOR Wilson Funeral Home

 ADDRESS Somerville, Mass.

 Received and filed Sept. 5, 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

 8 SEX female 9 COLOR white 10 SINGLE (write the word) single
 MARRIED WIDOWED DIVORCED UNKNOWN

 11 If married, widowed, or divorced HUSBAND of
 (Give maiden name of wife in full)

 (or) WIFE of
 (Husband's name in full)

 12 AGE 87 years 11 months 1 days If under 24 hours Hours Minutes

 13 Usual Occupation: retired attendant nurse
 (Kind of work done during most working life)
14 Industry or Business:
 15 Social Security No. unknown
 16 BIRTHPLACE (City) Charlestown
 (State or country) Mass.

 17 NAME OF FATHER Arthur F. Teel

 18 BIRTHPLACE OF FATHER (City) Charlestown
 (State or country) Mass.

 19 MAIDEN NAME OF MOTHER Marcella Canney

 20 BIRTHPLACE OF MOTHER (City) Charlestown,
 (State or country) Mass.

 21 Informant (Address) Mary E. Sheehan
Danvers, Mass.

A TRUE COPY

 ATTEST: Tracy I. Flagg
 (Registrar of City or Town where death occurred)
Health Agent August 30, 1963
DATE FILED 1963

DEC. 13, 1963

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED



DEC 13 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Denvers

(City or Town making this return)

PLACE OF DEATH

Denvers

(County)

Denvers

(City or Town)

No. **Denvers State Hospital, Hathorne** { (If death occurred in a hospital or institution, give its NAME instead of street and number)

Registered No. **244**

2 FULL NAME **Kathleen Walters (Kathleen Barry)**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a U. S. War Veteran if so specify WAR, **244**)

(a) Residence, No. **64 Udine Avenue, Winthrop, Mass.** St. **UNLINE**

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death **1** years **-** months **18** days. In place of residence **1** years **-** months **18** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **September 2, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **August 15, 1962** to **September 2, 1963**

I last saw him on **September 2, 1963** death is said to have occurred on the date stated above, at **3:30p.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Hodgkins' Disease (Granuloma)**

INTERVAL BETWEEN ONSET AND DEATH **months**

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? **no**
What test confirmed diagnosis? **Clin. & Lab.**

5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify

(Signed) **Willard M. Hausman** M. D.
Willard M. Hausman

(Address) **Hathorne, Mass.** Date **9/2/63**

6 **Winthrop Cometary, Winthrop, Mass.**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **September 4, 1963**

7 NAME OF FUNERAL DIRECTOR **Maurice W. Kirby**

ADDRESS **Winthrop, Mass.**

Received and filed **September 5, 1963**

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **female** 9 COLOR **white** 10 SINGLE (write the word) **married**
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of **Stephen J. Walters** (Give maiden name of wife in full)

(or) WIFE of **Stephen J. Walters** (Husband's name in full)

12 AGE **64** Years **11** Months **25** Days If under 24 hours
Hours Minutes

13 Usual Occupation **Housewife**
(Kind of work done during most working life)

14 Industry or Business

15 Social Security No. **unknown**

16 BIRTHPLACE (City) **West Newton, Mass.**
(State or country)

17 NAME OF FATHER **Michael Barry**

18 BIRTHPLACE OF FATHER (City) **unknown**
(State or country) **Ireland**

19 MAIDEN NAME OF MOTHER **Noreh Delenhanty**

20 BIRTHPLACE OF MOTHER (City) **unknown**
(State or country) **Ireland**

21 Informant **Mary E. Sheehan**
(Address) **Denvers, Mass.**

A TRUE COPY

ATTEST: **Tracy I. Flagg.**

Health Agent Sept. 7, 1963

DATE FILED **Dec. 13, 1963**

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED



DEC 13 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
 SECRETARY OF THE COMMONWEALTH
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

COPY OF
 CERTIFICATE OF DEATH

Registered No. 245

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Annabella Landrigan
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
 U. S. War Veteran,
 if so specify WAR, 245)

(a) Residence. No. Winthrop, Mass.
 (Usual place of abode)

St. Winthrop, Mass.
 (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 2 months 22 days. In place of residence 2 years 2 months 22 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 24, 1963
 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from July 25, 1961 to October 24, 1963

I last saw him alive on October 24, 1963 Death is said to have occurred on the date stated above, at 10:30p

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
Bronchial Pneumonia

(a) Days

Due To
 (b)

Due To
 (c)

OTHER
 SIGNIFICANT
 CONDITIONS

Arteriosclerotic Ht. dis. yrs
Generalized Arteriosclerosis yrs
no

Was autopsy performed? Clin. & Laboratory
 What test confirmed diagnosis? Clin. & Laboratory

5 Was disease or injury in any way related to occupation of deceased? no
 If so, specify no

(Signed) Willard M. Hausman M. D.
Willard M. Hausman

(Address) Hathorne, Mass. Date 10/24/63

Holy Cross Gen. Malden, Mass.
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 23, 1963

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS East Boston, Mass.

Received and filed October 30, 1963

Dec. 13, 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) widowed
 MARRIED
 WIDOWED
 DIVORCED
 UNKNOWN

11 If married, widowed, or divorced

HUSBAND of John Landrigan (Give maiden name of wife in full)

(or) WIFE of John Landrigan (Husband's name in full)

12 AGE 89 Years 1 Months 3 Days If under 24 hours
00 Hours 00 Minutes

13 Usual Occupation: unable to work
 (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. unknown

16 BIRTHPLACE (City) Newfoundland, Canada
 (State or country)

17 NAME OF FATHER James W. Scott

18 BIRTHPLACE OF FATHER (City) Newfoundland, Canada
 (State or country)

19 MAIDEN NAME OF MOTHER Margaret Stump

20 BIRTHPLACE OF MOTHER (City) unknown
 (State or country) Newfoundland, Canada

Mary E. Sheehan

21 Informant (Address) Danvers, Mass.

A TRUE COPY

ATTEST: Philip J. Toomey
 (Registrar of City or Town where death occurred)

DATE FILED October 30, 1963

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED



DEC 13 1963 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)



COPY OF
CERTIFICATE OF DEATH

Registered No.

246

No. Danvers, State Hosp. Hathorne

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

Henry A. Corinha, Sr.

no

2 FULL NAME. (If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR,

(a) Residence. No. 242 Lincoln St., Winthrop, Mass.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....1 months.....5 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 25, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
Sept. 20, 1963, to Oct. 25, 1963.

I last saw him live on October 25, 1963. Death is said to
have occurred on the date stated above, at 3:25 p.m.

INTERVAL
BETWEEN
ONSET AND
DEATH
3 days

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

Due To Anterior Myocardial inf
(b) arction 3 days

Due To
(c)

OTHER Arteriosclerotic ht. dis. yrs
SIGNIFICANT Gen. Arteriosclerosis yrs
CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? Clinical & Lab.

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Willard M. Hausman
Willard M. Hausman, M. D.

(Address) Hathorne, Mass. Date 10/25/63

Winthrop Cemetery Winthrop, Mass.

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 29, 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed Oct. 30, 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

white

10 SINGLE (write the word)

MARRIED
WIDOWED
DIVORCED
UNKNOWN

marrrrid

11 If married, widowed, divorced
HUSBAND of Kathleen Feenoy

(Give maiden name of wife in full)

(or) WIFE of.....

(Husband's name in full)

12 AGE 70 Years 2 Months 27 Days

If under 24 hours
.....Hours.....Minutes

13 Usual

Occupation:

(Kind of work done during most working life)

14 Industry

or Business:

15 Social Security No. 023-09-9916

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

17 NAME OF

FATHER

Anthony Corinha

18 BIRTHPLACE OF

FATHER (City)

Boston,

(State or country)

Mass.

19 MAIDEN NAME

OF MOTHER

Elizabeth Feenan

20 BIRTHPLACE OF

MOTHER (City)

Boston,

(State or country)

Mass.

21 Informant

(Address)

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

October 30, 1963

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED



DEC 13 1963 AM

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

(City or town making return)

Registered No. **247**

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)

No. **Danvers State Hosp.**

(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

2 FULL NAME **Edward Potvin B.**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) **10**

(a) Residence. No. **6 Pauline St.** **Winthrop, Mass.**
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death **16** years **0** months **14** days. In place of residence **16** years **0** months **14** days.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH **October 28, 1963**
(Month) (Day) (Year)

9 SEX **male** 10 COLOR **white** 11 CITIZEN OF U.S. YES ☐ NO ☐ 12 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE and MANNER thereof are as follows: (If an injury was involved, state fully.)

12a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

Heart Disease presumably coronary thrombosis sudden death

(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH

5 Accident, suicide, or homicide (specify) **no**
Date and hour of injury **19**

14 AGE **Years Months Days** If under 24 hours **Hours Minutes**

If accidental, was injury causally related to the death?

15 Usual Occupation: (Kind of work done during most of working life)

Where did injury occur? (City or town and State)

16 Industry or Business: **unknown**

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

17 Social Security No. **unknown Vermont.**

Manner of injury (How did injury occur?)

18 BIRTHPLACE (City) (State or country)

Nature of injury **no**

19 NAME OF FATHER **Edward Potvin B.**

While at work? Was autopsy performed? **no**

20 BIRTHPLACE OF FATHER (City) (State or country) **unknown**

6 Was disease or injury in any way related to occupation of deceased?

21 MAIDEN NAME OF MOTHER **unknown**

If so, specify **Douglas C. MacGillivray**

22 BIRTHPLACE OF MOTHER (City) (State or country) **unknown**

(Signed) **Douglas C. MacGillivray, M. D.**

(Address) **10 Berry St.** Date **10/29/1963**

23 Informant (Address) **E. Sheehan**

7 Place of burial **St. Mary's Cem.** (City or town) **Salisbury, Mass.**

23 Informant (Address) **E. Sheehan**

DATE OF BURIAL **November 4, 1963**

8 NAME OF FUNERAL DIRECTOR **W. H. Crosby, Inc.**

ADDRESS **Danvers, Mass.**

A TRUE COPY. ATTEST: **Paul J. T...** (Registrar of City or Town where death occurred)

Received and filed **November 5, 1963**

DATE FILED **Nov. 5, 1963**

(Registrar of City or Town where deceased resided)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



For burial permit
Board of Health
Agent.

CTIONS
OR
IFICATE

OR TYPE
R CAUSES
EATH

enter
than one
for each
b) and (c)

is not mean
of dying,
heart failure,
ic. It means
or compli-
which caused

is, if any,
have rise to
cause (a),
the under-
cause last.

ions contrib-
each but not
the terminal
dition given

195
57
x77

10 1964

OUT - OF - TOWN The Commonwealth of Massachusetts

SUFFOLK

(County)

BOSTON

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

248 11140

Registered No.

No. LEMUEL SHATTUCK HOSPITAL (If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME BARTOLO DiNovo (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, Korean if so specify WARI

(a) Residence. No. 16 PAINE ST. St. WINTHROP
(Usual place of abode) (City or town and State)

Length of stay: In place of death... years... months... 38 days. In place of residence... years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 14 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1963, to Nov. 14, 1963

I last saw him alive on NEVER, 19, death is said to have occurred on the date stated above, at 10:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMATOSIS

Due To (b) CARCINOMA OF ADRENAL

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Elita A. Channin, M. D.

ELITA A. CHANNIN

(Print or Type Name)

(Address) LEMUEL SHATTUCK HOSP. Nov. 14, 1963

6 Woodlawn Ceme. Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 18, 1963

7 NAME OF FUNERAL DIRECTOR Joseph P. Murphy

322 Bunker Hill St. Charlestown

ADDRESS

Received and filed NOV 19 1963

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED Married

11 If married, widowed, or divorced HUSBAND of Patricia Cummings (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 29 Years. Months Days If under 24 hours Hours Minutes

13 Usual Occupation Electrician (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No 021-26-9448

16 BIRTHPLACE (City) New York (State or country)

17 NAME OF FATHER Emanuel Di Novo

18 BIRTHPLACE OF FATHER (City) New York (State or country)

19 MAIDEN NAME OF MOTHER Elizabeth Gebro

20 BIRTHPLACE OF MOTHER (City) New Hampshire (State or country)

21 Informant William Leahy (Address) 5 Mystic St. Charlestown

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
D. Lempore B/1117 (Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 11/17/63

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

RECEIVED

Attest: [Signature] Clerk



JAN 10 1964 AM

FORM R-301

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
, (b) and (c)

does not mean
ode of dying,
heart failure,
etc. It means
ase, or compli-
which caused

itions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

Director
use only

ACK Int.
10 1964

-62-933404

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD
CERTIFICATE OF DEATH

Registered No. 249 1275

No. MASSACHUSETTS GENERAL HOSPITAL

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME Florence M. Ingalls

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, 110
if so specify WAR)

(a) Residence, No. 41 Washington Avenue

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death, 4 years, 10 months, 4 days. In place of residence, 10 years, 10 months, 4 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 14 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from November 10 1963 to November 14 1963

I last saw her alive on November 14 1963 death is said to have occurred on the date stated above, at 10:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) UREMIA

INTERVAL
BETWEEN
ONSET AND
DEATH

1 WK

(b) PYONEPHROSIS

YEARS

(c)

OTHER
SIGNIFICANT
CONDITIONSBOWEL FISTULAR MULTIPLE AND
SIGMOID VESICAL SINUS (YRS)

Was autopsy performed? Yes) ASSOC. WITH FOREIGN BODY

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Nov. 14 1963

6 Pine Grove Falmouth Foreside
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 16 1963

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St Winthrop

Recorded and filed

DEC 5 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Harold (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 85 Years 10 Months 19 Days If under 24 hours Hours Minutes

13 Usual Occupation Nurse (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Maine

17 NAME OF FATHER Unknown

18 BIRTHPLACE OF FATHER (City) (State or country) Unknown

19 MAIDEN NAME OF MOTHER Unknown

20 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

21 Informant Annie Connor

(Address) 17 Underhill St, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTENT:

William J. Kane.
City Registrar

RECEIVED



JAN 10 1964 AM

for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
the terminal
condition given

Medical
Examiner
Declined

10 1964

OUT - OF - TOWN

The Commonwealth of Massachusetts

Suffolk

(County)

Boston

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 250 11500

xx Veterans Administration Hospital xx

(If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Patrick F. Molloy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, WWI
if so specify WAR)

(a) Residence. No. 33 Bayview Ave.
(Usual place of abode)

xx Winthrop, Mass.
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 14 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased ~~xxxx~~
~~xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx~~
~~xxxxxxxx~~ on November 14 1963, death is said to
have occurred on the date stated above, at 1:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive recent antero-septal
myocardial infarction

Due To (b) Old postero-septal infarction

Due To (c) Acute right coronary thrombo-
sis minutes

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic aneurysm
abdominal aorta mos-yrs

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) *Richard Lucey*, M. D.

Richard Lucey

(Print or Type Name)

(Address) VAH/Boston, Mass. Date Nov. 15 1963

6 Winthrop Cem., Winthrop, Mass. .
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 18 1963

7 NAME OF FUNERAL DIRECTOR Morris Kirby

ADDRESS Winthrop, Mass.

Received and filed NOV 20 1963

William J. Kane
(Registrar)

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN Married

11 If married, widowed, or divorced
HUSBAND of Harriet Boyd
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 69 Years 8 Months 19 Days
If under 24 hours Hours Minutes

13 Usual Occupation Oiler, retired
(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. 033-34-8724

16 BIRTHPLACE (City) Lowell
(State or country) Mass.

17 NAME OF FATHER Domenick Molloy

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Murphy

20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant V. A. Hospital Records, 150 S.
(Address) Huntington Ave., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

R. A. Scraper
(Signature of Agent of Board of Health or other)
19255 11/15/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

RECEIVED

A TRUE COPY ATTEST:

William J. Kane
City Registrar



JAN 10 1964 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SOM-3-62-932695

PLACE OF DEATH

WORCESTER

(County)
GRAFTON

(City or Town)



The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

GRAFTON
(City or Town making this return)

251 182

Registered No.

No. Grafton State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Louis C. Sanderson (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence No. 240 Pleasant Street St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 45 years 8 months 8 days. In place of residence Not Learned years Not Learned months Not Learned days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 23, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden Death, Presumably Coronary Thrombosis.

5 Accident, suicide, or homicide (specify) None
Date and hour of injury None 1963

IF ACCIDENTAL, was injury causally related to the death? None

Where did Injury occur? None
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? None
(Specify type of place)

Manner of Injury None
(How did injury occur?)

Nature of Injury None
While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Walter F. Mahoney, M. D., M. D.

(Address) Westboro, Mass. Date Nov. 23, 1963

7 Hillcrest Cemetery, N. Grafton
Place of Burial or Cremation, (City or Town)

DATE OF BURIAL November 29, 1963

8 NAME OF FUNERAL DIRECTOR Misiaszek Funeral Home

ADDRESS 250 Main St., S. Grafton,

Received and filed DEC 11 1963 1963

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX <u>Male</u>	10 COLOR <u>White</u>	11 SINGLE (write the word) <u>Single</u>
----------------------	--------------------------	---

12 If married, widowed, or divorced
HUSBAND of None (Give maiden name of wife in full)
(or) WIFE of None (Husband's name in full)

13 AGE 68 Years 9 Months 12 Days If under 24 hours
Hours None Minutes None

14 Usual Occupation: None
(Kind of work done during most of working life)

15 Industry or Business: None

16 Social Security No. None

17 BIRTHPLACE (City) Boston, Mass.
(State or country)

PARENTS

18 NAME OF FATHER Charles W. Sanderson

19 BIRTHPLACE OF FATHER (City) Boston,
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Carrie S. Peterson

21 BIRTHPLACE OF MOTHER (City) Boston,
(State or country) Mass.

22 Informant (Address) Grafton, State Hosp. Records
North Grafton, Mass.

A TRUE COPY

ATTEST: Raymond L. L...
(Registrar of City or Town where death occurred)

DATE FILED December 3, 1963

SPACE FOR ADDITIONAL INFORMATION

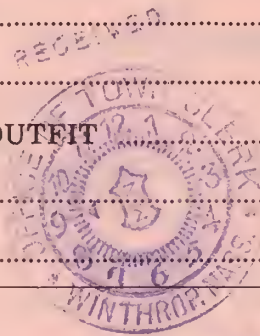
DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



DEC 1 1963 AM

for burial permit
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INSTRUCTIONS
FOR
CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. **252**

1

PLACE OF DEATH

Suffolk
(County)

Winthrop
(City or Town)

No. **15 Pleasant Park Road**

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

2 FULL NAME

Joseph F. Preg

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. **15 Pleasant Park Road**

(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death **50** years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 2, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
October 62 to **Dec 2**, 19**63**
I last saw him alive on **Dec 2**, 19**63** death is said to
have occurred on the date stated above, at **7:15 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebrovascular (Occlusion)** **6 mos**

Due To (b) **Cerebral Arteriosclerosis** **1 yr.**

Due To (c)

OTHER SIGNIFICANT CONDITIONS **None**

Was autopsy performed? **No**

What test confirmed diagnosis? **clinical**

5 Was disease or injury in any way related to occupation of deceased **No**
If so, specify

(Signature) **Charles Liberman**, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) **WINTHROP MASS.** Date **12/21** 19**63**

Holyhood Brookline Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **December 5** 19**63**

7 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**

ADDRESS **Winthrop Mass.**

Received and filed **DEC 4 - 1963** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed or divorced
HUSBAND of **Alice R. Howard**

(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE **86** Years.....Months.....Days If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: **Retired**
(Kind of work done during most working life)

14 Industry or Business: **Commercial Artist**

15 Social Security No.....

16 BIRTHPLACE (City).....
(State or country) **Germany**

17 NAME OF FATHER **Joseph Preg**

18 BIRTHPLACE OF FATHER (City).....
(State or country) **Germany**

19 MAIDEN NAME OF MOTHER **Anna Loeffler**

20 BIRTHPLACE OF MOTHER (City).....
(State or country) **Germany**

21 Informant (Address) **Veronica Preg**
15 Pleasant Park Road

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph B. Seranno
(Signature of Agent of Board of Health or other)
Health Officer **December 4 1963**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

V.B.V.



SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

DEC 4 1963 AM

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **253**

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 67 Atlantic Street

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

2 FULL NAME Grace (Peters) Tibbetts

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 67 Atlantic Street

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 50 years months days. In place of residence 52 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 6, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec. 4, 1963, to Dec. 6, 1963

I last saw her alive on December 6, 1963, death is said to
have occurred on the date stated above, at 8:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Thrombosis

INTERVAL
BETWEEN
ONSET AND
DEATH

3 days

Due To (a) Arteriosclerosis

(b)

5 yrs.

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

none

Was autopsy performed? no

What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John F. Collins, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 27 Barrington St. Date Dec. 9, 1963

6 Place of Burial or Cremation Winthrop

DATE OF BURIAL Dec. 10, 1963

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop

Received and filed DEC 9 - 1963 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED or DIVORCED

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Wesley Tibbetts
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 98 Years 6 Months 5 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Westport
(State or country) Nova Scotia

17 NAME OF FATHER Alfred Peters

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Adelaide Cann

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Elsie Tibbetts
(Address) 67 Atlantic St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued.
(Signature of Agent of Board of Health or other)
Health Officer December 9, 1963
(Official Designation) (Date of Issue of Permit)

301A

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SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

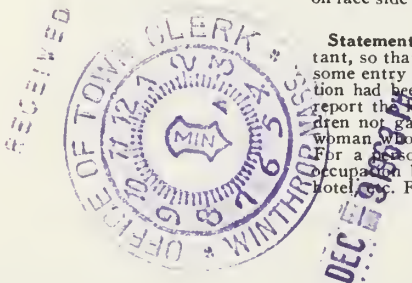
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **254**

PLACE OF DEATH

Burlington

(County)

Wintthrop

(City or Town)

No. **Bay View Nursing Home**

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Janie F. Muir (Fox)**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran, **no**
(if so specify WAR)

(a) Residence. No. **165 Bowdoin St.**
(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death **2** years **29** months **29** days. In place of residence **29** years **29** months **29** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Dec. 7, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **12/5/63**, 19**63**, to **12/7/63**, 19**63**.

I last saw her alive on **12/7/63**, 19**63**, death is said to have occurred on the date stated above, at **6:00 P.M.**

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebral Hemorrhage**

2 days

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Pneumonia

2 days

Was autopsy performed? **No**

What test confirmed diagnosis? **Autopsy**

5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify

(Signed) **Charles Liberman**, M.D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) **WINTHROP, MASS.** Date **DEC 7, 1963**

6 **Wintthrop Cemetery, Wintthrop**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Dec. 10, 1963**

7 NAME OF FUNERAL DIRECTOR **Ernest F. ...**
ADDRESS **147 Wintthrop St., Wintthrop**

Received and filed **DEC 10 1963** 19**63**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **female** 9 COLOR **white** 10 SINGLE (write the word)
MARRIED
WIDOWED **widowed**
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of **Lockhart I. Muir**
(Give maiden name of wife in full)
(or) WIFE of **Lockhart I. Muir**
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **53** Years **24** Months **24** Days
If under 24 hours
Hours Minutes

13 Usual Occupation: **Homemaker**
(Kind of work done during most of working life)

14 Industry or Business: **at home**

15 Social Security No.

16 BIRTHPLACE (City) **Boston**
(State or country) **Mass.**

17 NAME OF FATHER **George H. Fox**

18 BIRTHPLACE OF FATHER (City) **Dewsbury**
(State or country) **England**

19 MAIDEN NAME OF MOTHER **Louisa Downes**

20 BIRTHPLACE OF MOTHER (City) **Unland**
(State or country) **Pennsylvania**

21 Informant **John Fox**
(Address) **165 Bowdoin St., Wintthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph B. ...
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) **Dec 10 1963** (Date of Issue of Permit)

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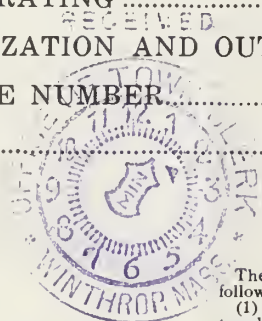
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SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....



DEC 10 1963

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk
(County)

Winthrop

(City or Town)

No.

Bayview Nursing Home

2 FULL NAME Solomon Lefkofsky

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

(Usual place of abode)

129 Stanwood

St.

Roxbury

(If nonresident, give city or town and State)

Length of stay: In place of death... years... 1 months... days. In place of residence... 31 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 11, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from

Nov 3, 1963, to Dec 11, 1963

I last saw him alive on Dec 10, 1963, death is said to have occurred on the date stated above, at 9:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease

INTERVAL
BETWEEN
ONSET AND
DEATH

1 yr

(b) Generalized Arteriosclerosis 3 yrs.

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS

None

Was autopsy performed?

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signed)

Charles Liberman
CHARLES LIBERMAN

M.D.

(Address)

WINTHROP, MASS. Date 12/11/1963

6 Roxbury Lodge, West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 12, 1963

7 NAME OF
FUNERAL DIRECTOR

ADDRESS 10 Washington St. Dorch.

Received and filed

DEC 12 1963

19

(Registrar)

The Commonwealth of Massachusetts

JOSEPH D WARD

SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.

Registered No.

255

{(If death occurred in a hospital or institution,
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a
U. S. War Veteran,
if so specify WAR)

No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED
WIDOWED
or DIVORCED Married10a If married, with
HUSBAND of Bertha Novick

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 82

Years... Months... Days

If under 24 hours

Hours... Minutes

13 Usual

Occupation:

Coal Dealer

(Kind of work done during most of working life)

14 Industry

or Business:

Retired

15 Social Security No. 016-12-4878

16 BIRTHPLACE (City)

(State or country)

Poland

17 NAME OF
FATHER

Louis Lefkofsky

18 BIRTHPLACE OF

FATHER (City)

Poland

(State or country)

19 MAIDEN NAME

OF MOTHER

Rachael (CBL)

20 BIRTHPLACE OF

MOTHER (City)

Poland

(State or country)

21

Informant

(Address)

Jimmy Lewis

129 Stanwood St. Roxbury

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph C. Sirianesi
(Signature of Agent of Board of Health or other)Health Officer
(Official Designation)Dec 11 1963
(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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DEC 12 1963 PM

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

STANDARD CERTIFICATE OF DEATH

Registered No. **256**

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

2 FULL NAME **Lillian (Walsh) Clough**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. **105 Grover Avenue**
(Usual place of abode)

St. **West Winthrop, Mass.**
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months **22** days. In place of residence.....years **2** months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Dec. 12, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
11/20, 19**63**, to **12/12**, 19**63**

I last saw him live on **Dec. 11**, 19**63** death is said to
have occurred on the date stated above, at **12:20** a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Carcinomatosis** **22 days**
Due To (b) **Primary Lesion - Uterus** **2 yrs.**
Due To (c) **Carcinoma of the Brain** **22 days**

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? **No**
What test confirmed diagnosis? **History and Path. Findings**

5 Was disease or injury in any way related to occupation of deceased?
If so, specify **No**

(Signature) **Harold L. Musgrave, M.D.**, M. D.
(Print or Type Name)

(Address) **620 Beach Street** Date **12/12**, 19**63**

6 **Revere** **West Winthrop**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Dec. 14**, 19**63**

7 NAME OF FUNERAL DIRECTOR **Lowell J. Reynolds**

ADDRESS **Winthrop, Mass.**

Received and filed **DEC 13 1963**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of **Herbert Clough**
(Husband's name in full)

12 AGE **73** Years **7** Months **23** Days
If under 24 hours
.....Hours.....Minutes

13 Usual Occupation: **Housewife**
(Kind of work done during most working life)

14 Industry or Business: **U.S. Navy**

15 Social Security No. **03-26-2200**

16 BIRTHPLACE (City)
(State or country) **New York**

17 NAME OF FATHER **William Walsh**

18 BIRTHPLACE OF FATHER (City)
(State or country) **Canada**

19 MAIDEN NAME OF MOTHER **Mary Motero t**

20 BIRTHPLACE OF MOTHER (City)
(State or country) **New York**

21 Informant (Address)
Winthrop Community Hospital

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirisui (Signature of Agent of Board of Health or other) (MB)
Health Officer **12/13/63**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
.....

RECEIVED



DEC 13 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **257**

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. **28 James Ave**

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Laud (Linda) Overturf**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. **28 James Ave**
(Usual place of abode)

St. _____
(If nonresident, give city or town and State)

Length of stay: In place of death **4** years..... months..... days. In place of residence **60** years..... months..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 13 - 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
I last saw h..... alive on 19....., death is said to
have occurred on the date stated above, at **7:30 A. m.**

INTERVAL
BETWEEN
ONSET AND
DEATH

1 Hour

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Presumably Coronary Occlusion**

Due To **Natural Causes**

(b)

Due To
(c)

OTHER
SIGNIFICANT
CONTRIBUTING
CAUSES

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) **John F. Collins MD** M. D.
John F. Collins MD
(PRINT OR TYPE SIGNATURE) **13 Dec 1963**
(Address) **22 Bennington St. Revere** Date **14 Dec 1963**

6 Place of Burial or Cremation
(City or Town)
DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR
ADDRESS

Received and filed **DEC 16 1963** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED **Widow**

10a If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)

(or) WIFE of **Linda Overturf**
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **59** Years **3** Months **3** Days
If under 24 hours
..... Hours..... Minutes

13 Usual Occupation: **Housewife**
(Kind of work done during most of working life)

14 Industry or Business: **None**

15 Social Security No. **151-10-1011**

16 BIRTHPLACE (City)
(State or country) **Canada**

17 NAME OF FATHER **John Edward**

18 BIRTHPLACE OF FATHER (City)
(State or country) **Canada**

19 MAIDEN NAME OF MOTHER **Chausse**

20 BIRTHPLACE OF MOTHER (City)
(State or country) **Canada**

21 Informant (Address) **John F. Collins MD**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Suranick
(Signature of Agent of Board of Health or other)

Death Officer **December 16, 1963**
(Official Designation) (Date of Issue of Permit)

-301A

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CERTIFICATE

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SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town in which the deceased resided at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Stoneham

(City or Town making this return)

258 291

Registered No.

PLACE OF DEATH

Middlesex
(County)

Stoneham

(City or Town)

No. New Eng. San. & Hosp.

COPY OF
CERTIFICATE OF DEATH(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

2 FULL NAME **James Ruggiero**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran,
if so specify WAR, no

(a) Residence. No. **113 Revere** St. **Winthrop**
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 15, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
12/8 in **63** to **12/15** in **63**
I last saw him live on **12/15** in **63**, death is said to
have occurred on the date stated above, at **12:30p.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Pneumonitis, myocarditis**INTERVAL
BETWEEN
ONSET AND
DEATH
1 wk.Due To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? **no**
What test confirmed diagnosis? **X-ray - EKG**

5 Was disease or injury in any way related to occupation of deceased **no**
If so, specify

(Signed) **John Verdone, M.D.**, M. D.(Address) **Medford, Mass.** Date **12/17** in **63**

6 **Holy Cross Cen.** **Malden**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **December 18,** in **63**7 NAME OF FUNERAL DIRECTOR **Anthony P. Rapino**ADDRESS **9 Chelsea St., E. Boston, Mass.**Received and filed **DEC 23 1963** in

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **male** 9 COLOR **white** 10 SINGLE (write the word)
MARRIED **WIDOWED** **DIVORCED** **UNKNOWN**

11 If married, widowed, or divorced
HUSBAND of **Josephine Antonelli**
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 **64** Years, Months, Days If under 24 hours
AGE **64** Hours, Minutes

13 Usual Occupation: **Furniture dealer**
(Kind of work done during most working life)

14 Industry or Business: **Self employed**

15 Social Security No. **15-20-0333**

16 BIRTHPLACE (City) **Boston**
(State or country) **Mass.**

17 NAME OF FATHER **Nicholas Ruggiero**

18 BIRTHPLACE OF FATHER (City) **Italy**
(State or country)

19 MAIDEN NAME OF MOTHER **Maria Clericuzio**

20 BIRTHPLACE OF MOTHER (City) **Italy**
(State or country)

21 Informant (Address) **Josephine Ruggiero (wife)**
113 Revere St., Winthrop, Mass.

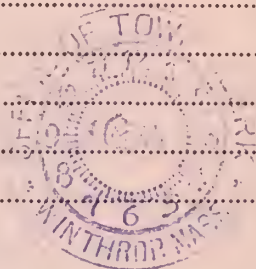
A TRUE COPY

ATTEST: **December 18,** 19 **63**
(Registrar of City or Town where death occurred)

DATE FILED **December 18,** 19 **63**

TV

SPACE FOR ADDITIONAL INFORMATION.....
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING.....
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....
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DEC 23 1963 PM

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk
(County)

Winthrop

(City or Town)

No. 143 Court Road

STANDARD
CERTIFICATE OF DEATH

Registered No. 259

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Wisher, Elizabeth (Kitson) Thomas
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran,
if so specify WAR) NO.(a) Residence. No. 143 Court Road,
(Usual place of abode)St. Winthrop, Massachusetts
(If nonresident, give city or town and State)Length of stay: In place of death. 45 years.....months.....days. In place of residence 45 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 15, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw him alive on 19....., death is said to
have occurred on the date stated above, at 5:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary OcclusionDue To (b) Natural causesDue To (c) Normal for the Winthrop
Board of HealthOTHER
SIGNIFICANT
CONDITIONSWas autopsy performed? noWhat test confirmed diagnosis? clinical findings5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signature) John F. Collins M.D., M. D.John F. Collins M.D.
(Print or Type Name)(Address) 27 Harrington St. Date Dec. 16, 19636 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)DATE OF BURIAL December 18, 19637 NAME OF FUNERAL DIRECTOR Alfred B. MarshADDRESS 174 Winthrop St. WinthropReceived and filed DEC 18 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED widowed
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Edward Armstrong Thomas
(Give maiden name of wife in full)
(Husband's name in full)12 AGE 84 Years 2 Months 20 Days If under 24 hours
Hours.....Minutes13 Usual Occupation: housewife
(Kind of work done during most working life)14 Industry or Business: own home15 Social Security No. 22-10-061916 BIRTHPLACE (City) Boston
(State or country) Massachusetts17 NAME OF FATHER John Kitson18 BIRTHPLACE OF FATHER (City) England
(State or country)19 MAIDEN NAME OF MOTHER Elizabeth Patton20 BIRTHPLACE OF MOTHER (City) England
(State or country)21 Informant Barbara E. Thomas
(Address) 143 Court Road, WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death
has been filed with me BEFORE the burial or transit permit was issued:Ralph C. Seaman (R)
(Signature of Agent of Board of Health or other)
Health Officer December 18, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

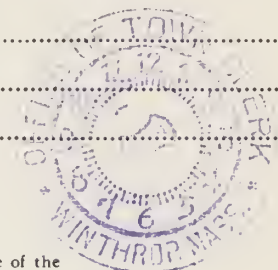
RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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RECEIVED



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

DEC 18 1963 AM

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATHRegistered No. **260**

PLACE OF DEATH

Suffolk
(County)
Winthrop
(City or Town)

No. *224 Court Rd*(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Marie A Jordan (Vincent)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) *No*

(a) Residence. No. *224 Court Rd*

(Usual place of abode)

St. *Winthrop*

(City or town and State)

Length of stay: In place of death *2* years *2* months *2* days. In place of residence *2* years *2* months *2* days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

December 16, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec. 13, 1963 to *Dec. 16, 1963*

I last saw *her* alive on *Dec. 16, 1963*, death is said to
have occurred on the date stated above, at *9:35 P.M.*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Metastatic Carcinoma*INTERVAL
BETWEEN
ONSET AND
DEATH*6 mos*Due To *Primary Carcinoma of Breast*(b) *Primary Carcinoma of Breast**3 yrs*

Due To

(c)

OTHER
SIGNIFICANT
CONDITIONS*none*Was autopsy performed? *no*What test confirmed diagnosis? *Pathologic Specimen*5 Was disease or injury in any way related to occupation of deceased? *no*

If so, specify

(Signature) *John F. Collins M.D.*

John F. Collins M.D.
(Print or Type Name)

(Address) *27 Fennington St.* Date *Dec. 17, 1963*

St Marys *Scituate Mass*
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *Dec 19, 1963*7 NAME OF FUNERAL DIRECTOR *Ernest Plaggrand*ADDRESS *147 Winthrop St Winthrop*Received and filed *DEC 18 1963*

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female *White* *MARRIED*
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)
(or) WIFE of *Charles Jordan*
(Husband's name in full)

12

AGE *71* Years *11* Months *10* Days

If under 24 hours

Hours *0* Minutes *0*

13 Usual

Occupation

Housewife

(Kind of work done during most of working life)

14 Industry

or Business

at home

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Boston
Mass

17 NAME OF

FATHER

Louis Vincent

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Boston
Mass

19 MAIDEN NAME

OF MOTHER

Ugnes Kelly

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Boston
Mass

21 Informant

(Address)

Agnes Dooley
*224 Court Rd Winthrop*I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seranni
(Signature of Agent of Board of Health or other)

Health Officer *December 8, 1963*
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....



RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

261

PLACE OF DEATH

Suffolk
(County)
Wentworth
(City or Town)

No.

54 Centre St

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

Patrick H. Broadwater
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a
U. S. War Veteran, *WW 11*
if so specify WAR)

(a) Residence, No.

(Usual place of abode)

St.

Wentworth Mass
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF
DEATH

December 17, 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at 2:55 p.m.INTERVAL
BETWEEN
ONSET AND
DEATH
2 hrs.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Presumably Coronary Occlusion

Due To

(b) Heart Condition treated at

Due To

(c) Death due to Natural Causes

OTHER
SIGNIFICANT
CONDITIONS
formed for "Hinterop" board of
Health.

Was autopsy performed?

no

What test confirmed diagnosis?

clinical

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) John F. Collins M.D.

(Print or Type Name)

(Address)

27 Jennings St

Date

Dec. 18, 1963

6

Place of Burial or Cremation

DATE OF BURIAL

Dec 20 23 1963

7 NAME OF

FUNERAL DIRECTOR

Ernest P. Caggiano

ADDRESS

147 Wentworth St. Wentworth

Received and filed

19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Male

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

Widowed

11 If married, widowed, divorced
HUSBAND of

Sadie Jennings

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation

Retired Clerk

(Kind of work done during most of working life)

14 Industry

or Business

15 Social Security No.

078-24-

16 BIRTHPLACE (City)

(State or country)

Massachusetts

17 NAME OF

FATHER

?

(B L)

18 BIRTHPLACE OF

FATHER (City)

(State or country)

?

(B L)

19 MAIDEN NAME

OF MOTHER

?

(B L)

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

?

(B L)

21 Informant

Rena Wallace

(Address)

130 Grove Ave Wentworth

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni (S)

(Signature of Agent of Board of Health or other)

Health officer

December 18 1963

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

June 1 1919

DATE OF DISCHARGE

June 16 1947

RANK, RATING

Chief Pharmacist Mate

ORGANIZATION AND OUTFIT

U.S. Navy

SERVICE NUMBER

276-61-80

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



DEC 1 8 1963 PM

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **262**

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME John Thompson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 29 Cora Street

(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 7 years 50 months 7 days. In place of residence 50 years 50 months 7 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 18 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Jan, 1955, to Dec, 18, 1963.
I last saw him alive on Dec 18, 1963, death is said to
have occurred on the date stated above, at 10:00 a.m.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) congestive heart failure

Due To (h) arteriosclerosis

Due To (c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased?
If so, specify No

(Signed) H. B. Greenfield, M. D.

(Address) 447 Shirley St Date 12-18, 1963

6 Winthrop Mass Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec, 20 63

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed DEC 19 1963 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
or DIVORCED

10a If married, widowed, or divorced
HUSBAND of Edw. E. Dyer
(Give maiden name of wife in full)

(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 93 Years 1 Months 3 Days If under 24 hours
Hours Minutes

13 Usual Occupation: Plasterer retired
(Kind of work done during most of working life)

14 Industry or Business: Contractor

15 Social Security No. 025-14-7240

16 BIRTHPLACE (City)
(State or country) Prince Edward Island

17 NAME OF FATHER Joseph Thompson

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Esther Mershon

20 BIRTHPLACE OF MOTHER (City)
(State or country) Unable to obtain

21 Informant Marion Macell
(Address) 447 Shirley St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Siemann (B)
(Signature of Agent of Board of Health or other)

Health Officer Dec. 19, 1963
(Official Designation) (Date of Issue of Permit)

T 262 V

EXTRACTS
FROM THE LAWS OF THE
COMMONWEALTH OF MASSACHUSETTS
GOVERNING THE
RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and forty-two, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal, or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

DEC 19 1963 **RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

R-301A

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SUFFOLK
(County)WINTHROP
(City or Town)

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSSTANDARD
CERTIFICATE OF DEATHTo be filed for burial permit
with Board of Health
or its Agent.Registered No. **263**MAYFLOWER NURSING HOME 39 GROVERS' AVE.
No.(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)2 FULL NAME **MARIA IANNELLO**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

29 FAIRFIELD ST.**REVERE**(a) Residence. No. _____
(Usual place of abode)

St. _____

(If nonresident, give city or town and State)

Length of stay: In place of death 2 years 6 months _____ days. In place of residence 35 years _____ months _____ days.

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, **NO**
if so specify WAR)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Dec 1963**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Jan 53 to **Dec 1963**, 19____I last saw him alive on **Dec 19**, 19**63** death is said to
have occurred on the date stated above, at **3:20 P. m.**INTERVAL
BETWEEN
ONSET AND
DEATH**9 mos**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebral Hemorrhage**Due To **GENERALIZED ARTERIO-SCLEROSIS**
(b) **HYPERTENSIVE HEART DISEASE**Due To **HYPER TENSION**
(c) **10 yrs**OTHER SIGNIFICANT CONDITIONS **CARDIAC FAILURE**
1 dayWas autopsy performed? **no**

What test confirmed diagnosis? _____

5 Was disease or injury in any way related to occupation of deceased? **no**
If so, specify _____(Signed) **ANDREW CARLINO** M. D.(Address) **603 Broadway Res.** Date **DEC 20 1963**6 **HOLI CROSS CEMETERY, MALDEN, MASS.**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **DECEMBER 23, 1963** 19____7 NAME OF FUNERAL DIRECTOR **LAWRENCE BRUNO**
ADDRESS **291 REVERE ST. REVERE, MASS.**Received and filed **DEC 20 1963** 19____
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **FEMALE** 9 COLOR **WHITE** 10 SINGLE (write the word)
MARRIED
WIDOWED **SINGLE**
or **DIVORCED**

10a If married, widowed, or divorced

HUSBAND of _____
(Give maiden name of wife in full)(or) WIFE of _____
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **30** Years **9** Months **4** Days If under 24 hours
Hours _____ Minutes _____13 Usual Occupation: **None**
(Kind of work done during most of working life)14 Industry
or Business: _____15 Social Security No. **None**16 BIRTHPLACE (City) _____
(State or country) **ITALY**17 NAME OF FATHER **DOMENIC IANNELLO**18 BIRTHPLACE OF FATHER (City) _____
(State or country) **ITALY**19 MAIDEN NAME OF MOTHER **ROSE FERRARA**20 BIRTHPLACE OF MOTHER (City) _____
(State or country) **ITALY**21 Informant **DOMENIC CARNABUSCI (NEPHEW)**
(Address) **29 FAIRFIELD ST. REVERE, MASS.**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:**Joseph C. Scrammi R.**
(Signature of Agent of Board of Health or other)**Health Officer** **December 20, 1963**
(Official Designation) (Date of Issue of Permit)

RECEIVED



SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

DEC 2 0 1963 AM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

To be filed for burial permit
with Board of Health
or its Agent.

STANDARD CERTIFICATE OF DEATH

Registered No. **264**

PLACE OF DEATH

Suffolk
(County)
Wintthrop
(City or Town)



No. *Bayview Nursing Home*

St. { (If death occurred in a hospital or institution,
give its NAME instead of street and number)

2 FULL NAME *Julik Wallace*

If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) *ne*

(a) Residence. No. *16 Sunset Road*

St. (If nonresident, give city or town and State)

Length of stay: In place of death. *2* years. months days. In place of residence. *6* years. months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *DEC 25 1963*
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from *FEB 57* to *DEC 25 63*

I last saw him alive on *12/25/63*, death is said to have occurred on the date stated above, at *12:03 P.*m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *CORONARY OCCLUSION*

INTERVAL
BETWEEN
ONSET AND
DEATH
5 MIN

Due To *ARTERIO-SCLEROTIC HEART DISEASE* *1240*

Due To *GENERAL ARTERIOSCLEROSIS* *1240*

OTHER SIGNIFICANT CONDITIONS *NONE*

Was autopsy performed? *No*

What test confirmed diagnosis? *CLINICAL*

5 Was disease or injury in any way related to occupation of deceased? *No*
If so, specify

(Signed) *Myron N. King*, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) *211 PLEASANT ST.* Date *12/25-63*

6 *Place of Burial or Cremation* *Wintthrop*
DATE OF BURIAL *Dec 26 1963*

7 NAME OF FUNERAL DIRECTOR *Jeff Funeral Service*
ADDRESS *Chelsea*

Received and filed *DEC 26 1963* 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX *Male* 9 COLOR *White* 10 ~~SINGLE~~ (write the word) *MARRIED*
WIDOWED or *DIVORCED*

10a If married, widowed, or divorced
HUSBAND of *Bessie Berchansky*
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE *87* Years — Months — Days If under 24 hours
Hours — Minutes

13 Usual Occupation: *Tailor*
(Kind of work done during most of working life)

14 Industry or Business: *Clothing Mfg.*

15 Social Security No. *032-16-1055*

16 BIRTHPLACE (City) *Russia*
(State or country)

17 NAME OF FATHER *Caron Wallace*

18 BIRTHPLACE OF FATHER (City) *Russia*
(State or country)

19 MAIDEN NAME OF MOTHER *E. B. Z.*

20 BIRTHPLACE OF MOTHER (City) *Russia*
(State or country)

21 Informant (Address) *Eleanor Higgins*
16 Sunset Rd Wintthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Reginald E. Brown
(Signature of Agent of Board of Health or other)

Health Officer *Dec 26 1963*
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



DEC 26 1963 AM

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. **265**

Suffolk
(County)

Winthrop
(City or Town)

No. **170 Circuit Road**(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Leo H. Overlan**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, WW # **1**
if so specify WAR)

(a) Residence. No. **170 Circuit Road**
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death **20** years.....months.....days. In place of residence **20** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 26, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to
have occurred on the date stated above, at **10:25 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Death Presumably due to**
natural causes probably
acute coronary occlusion
(b) **on basis of history and**
examination.

OTHER
SIGNIFICANT
CONDITIONS

Winthrop Board of Health
Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased
If so, specify **10**

(Signature) **Charles Liberman, M.D.**
CHARLES LIBERMAN
(Print or Type Name)

(Address) **WINTHROP,** Date **12/27/1963**

6 **Winthrop** **Winthrop**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **December 30** 19**63**

7 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**

ADDRESS **Winthrop, Mass**Received and filed **DEC 30 1963** 19**63**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED
WIDOWED
WIDOWED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of **Hanora Murphy**
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE **69** Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation **Retired Book binder**
(Kind of work done during most working life)

14 Industry or Business **Book Binding**

15 Social Security No. **033-34-9072**

16 BIRTHPLACE (City) **Boston**
(State or country) **Mass**

17 NAME OF FATHER **John Overlan**

18 BIRTHPLACE OF FATHER (City) **Syracuse**
(State or country) **New York**

19 MAIDEN NAME OF MOTHER **Alice O'Connor**

20 BIRTHPLACE OF MOTHER (City).....
(State or country) **Ireland**

21 Informant **Lillian Abbott**
(Address) **31 Palmyra St., Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Nisioanni
(Signature of Agent of Board of Health or other) (H8)

Death Office **12/30/63**
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....12-11-17

DATE OF DISCHARGE.....7-25-19

RANK, RATING.....MM 2cl

ORGANIZATION AND OUTFIT.....U.S. Navy

SERVICE NUMBER.....174 38 36

RECEIVED

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



DEC 30 1963 PM

burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK
(County)

WINTHROP
(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. **266**

No. **45 NEPTUNE AVE.**

{(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME **MAURICE MORRIS SANDLER**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WARI) **No**

(a) Residence. No. **45 NEPTUNE AVE.** St. **WINTHROP**
(Usual place of abode) (City or town and State)

Length of stay: In place of death **20** years.....months.....days. In place of residence **20** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **DECEMBER 26, 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h..... alive on....., 19....., death is said to
have occurred on the date stated above, at **8:00 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Death presumably due**

(b) **to natural causes,**

(c) **probably acute coronary**

OTHER SIGNIFICANT CONDITIONS **Wintthrop Board of Health**

Was autopsy performed? **Charles Liberman M.D.**
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? **No**
If so, specify

(Signature) **Charles Liberman** M. D.
CHARLES LIBERMAN

(Address) **WINTHROP, MASS., Date 12/27/1963**

6 **BNAI BRITH OF SOMERVILLE - PEARBODY**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **DECEMBER 29, 1963**

7 NAME OF FUNERAL DIRECTOR **BENJAMIN BIRNIBACH**

ADDRESS **1668 BEACON ST., BROOKLINE**

Received and filed **DEC 30 1963** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE	9 COLOR WHITE	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
----------------------	-------------------------	--

11 If married, widowed, or divorced
HUSBAND of **FRANCES GOLDMAN**
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 AGE **59** Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation **EXECUTIVE**
(Kind of work done during most of working life)

14 Industry or Business **TOWN PAINT & SUPPLY**

15 Social Security No. **TO BE FILED LATER**

16 BIRTHPLACE (City) **EAST BOSTON, MASS.**
(State or country)

17 NAME OF FATHER **LOUIS SANDLER**

18 BIRTHPLACE OF FATHER (City) **RUSSIA**
(State or country)

19 MAIDEN NAME OF MOTHER **BELLA FREEDMAN**

20 BIRTHPLACE OF MOTHER (City) **POLAND**
(State or country)

21 Informant **MRS. FRANCES SANDLER**

(Address) **45 NEPTUNE AVE., WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Soriani (Signature of Agent of Board of Health or other) (40)

Health Officer (Official Designation) **Dec. 28, 1963** (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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DEC 30 1963 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSWinthrop
(City or Town making this return)STANDARD
CERTIFICATE OF DEATH

Registered No. 267

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Reilly
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran, No
if so specify WAR)(a) Residence, No. 29 Irwin St., Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, 5 years, months, days. In place of residence, 20 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 27, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
JAN 51 to DEC 27 1963

I last saw him live on DEC 27 1963, death is said to

have occurred on the date stated above, at 3:27 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE PULMONARY EMBOLUS

(b) ADENOCARCINOMA OF SIGMOID COLON

(c) CHRONIC BRONCHITIS & EMPHYSEMA

INTERVAL
BETWEEN
ONSET AND
DEATH

9 MRS.

4 MOS

12 YRS

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signature) Myron N. King M.D.

MYRON N. KING M.D.

(Print or Type Name)

(Address) 222 Pleasant St., Winthrop, Mass. Date 12/27/63

6 Winthrop Mass Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 30 1963

7 NAME OF FUNERAL DIRECTOR Ernest Plaggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed DEC 30 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED Divorced Married
UNKNOWN11 If married, widowed or divorced
HUSBAND of Elizabeth Reilly (Henderson)
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 58 Years 10 Months 10 Days
If under 24 hours Hours Minutes13 Usual Occupation Buyer
(Kind of work done during most working life)

14 Industry or Business Dept Store

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass

17 NAME OF FATHER James Reilly

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Nellie McCarthy

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)21 Informant Richard J. Reilly
(Address) 1 Vista Drive Danvers MassI HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sirisanni
(Signature of Agent of Board of Health or other) (N.B.)Health Officer 12/30/63
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

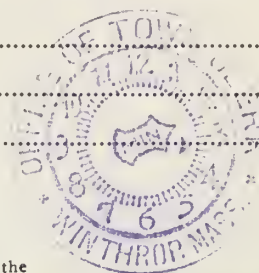
RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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RECEIVED



DEC 30 1963 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICSTo be filed for burial permit
with Board of Health
or its Agent.STANDARD
CERTIFICATE OF DEATHRegistered No. **268**

PLACE OF DEATH

Suffolk
(County)Winthrop
(City or Town)No. **Bay View Nursing Home**(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Hilmer J. Hanson**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)(a) Residence. No. **35 Moore St.**
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death **3** years **3** months **10** days. In place of residence **10** years **3** months **10** days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **DEC. 29 1963**
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
MARCH 29, 19**54**, to **DEC. 29**, 19**63**
I last saw him alive on **DEC. 27**, 19**63**, death is said to
have occurred on the date stated above, at **12:20 p.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **CARCINOMA OF URINARY
BLADDER**INTERVAL
BETWEEN
ONSET AND
DEATH
6 mosDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONS**GENERALIZED
ARTERIO SCLEROSIS****9 yrs**

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify(Signed) **M. Traubert**, M. D.**M. TRAUBERT, M.D.**
(PRINT OR TYPE SIGNATURE)(Address) **22 BARTLETT ST. WINTHROP, MASS.** Date **DEC. 29, 1963**6 **Glenwood Cemetery** **Everett**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Dec. 31, 1963**7 NAME OF FUNERAL DIRECTOR **J.E. Henderson Co.**ADDRESS **517 Broadway** **Everett**Received and filed **DEC 30 1963** 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)
MARRIED Married
WIDOWED or DIVORCED10a If married, widowed, or divorced
HUSBAND of **Ruth M. Johansson**
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **94** years **8** months **12** days If under 24 hours
Hours Minutes13 Usual Occupation: **Machinist Retired**
(Kind of work done during most of working life)14 Industry or Business: **Clifford Manufacturing**15 Social Security No. **025-09-9784**16 BIRTHPLACE (City) **Sweden**
(State or country)17 NAME OF FATHER **Hanson**18 BIRTHPLACE OF FATHER (City) **Sweden**
(State or country)19 MAIDEN NAME OF MOTHER **unknown**20 BIRTHPLACE OF MOTHER (City) **Sweden**
(State or country)21 Informant **Mrs. Evelyn Kratman**
(Address) **35 Moore St. Winthrop, Mass**I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:**Ralph S. Swann**
(Signature of Agent of Board of Health or other) (48)**Health Officer** **12/30/63**
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RECEIVED



DEC 30 1963

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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RM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No. **269**

No. **Winthrop Community Hospital** (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

2 FULL NAME **Frank S. Maiellano**
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) **no**

(a) Residence, No. **204 Shirley Street** St. **Winthrop, Mass.**
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....**1** days. In place of residence.....**35** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 31 1963**
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from **Dec 27** to **Dec 31**, 19**63**
I last saw him alive on **Dec 31**, 19**63**, death is said to have occurred on the date stated above, at **22³⁰ A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) **Coronary Thrombosis**

Due To **Arteriosclerosis**
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS **Bronchopneumonia**

Was autopsy performed? **No**
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify **No**

(Signature) **G. GUY STRAND**, M. D.
Print or Type Name **Richard C. Kirby Inc.**
(Address) **247 Huntington St., E. Boston** Date **1/31/64**

6 **Holy Cross** **Malden**
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **January 2, 1964**

7 NAME OF FUNERAL DIRECTOR **Richard C. Kirby Inc.**

ADDRESS **217 Huntington St., E. Bos.**

Received and filed **JAN 3 1964**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **M** 9 COLOR **W** 10 SINGLE (write the word) **MARRIED Married**
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of **Anna Maria Pelosi**
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 **77** Years **25** Days
AGE (If under 24 hours Hours Minutes)

13 Usual Occupation **Repairman**
(Kind of work done during most working life)

14 Industry or Business **Shoe Machinery**

15 Social Security No **011-15-6326**

16 BIRTHPLACE (City) **Italy**
(State or country)

17 NAME OF FATHER **Joseph Maiellano**

18 BIRTHPLACE OF FATHER (City) **Italy**
(State or country)

19 MAIDEN NAME OF MOTHER **Caroline Paradiglitti**

20 BIRTHPLACE OF MOTHER (City) **Italy**
(State or country)

21 Informant **Alphonso Maiellano - Son**
(Address) **Marblehead, Mass.**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) **Health Officer**
(Official Designation) (Date of Issue of Permit) **January 2, 1964**

A TRUE COPY ATTEST:

93282

SPACE FOR ADDITIONAL INFORMATION.....
 DATE OF ENTERING MILITARY SERVICE.....
 DATE OF DISCHARGE.....
 RANK, RATING.....
 ORGANIZATION AND OUTFIT.....
 SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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JAN 3 1964 PM

RM R-301

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PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

Gaetano

2 FULL NAME Guy Frizzi

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 10 Locust Street
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 19 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That attended deceased from
November 17, 1963, to November 19, 1963

I last saw him live on November 19, 1963, death is said to
have occurred on the date stated above, at 2:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

Due To (b) Arteriosclerotic heart
disease

Due To (c)

OTHER CHRONIC CONDITIONS Chronic bronchitis and
emphysema
Diabetes mellitus

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) C. C. Clay, M. D.

Charles L. Clay, M. D.
(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Nov. 19, 1963

6 St. Michael Cemetery Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 22, 1963

7 NAME OF FUNERAL DIRECTOR Vincent R. Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed

NOV 27 1963

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS



270

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

11641

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced Jennie Bonfiglio
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 74 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation Retired
(Kind of work done during most of working life)

14 Industry or Business *****

15 Social Security No. 025-09-0148

16 BIRTHPLACE (City) Italy
(State or country)

17 NAME OF FATHER Angelo Frizzi

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Victoria Bonasera

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Sarno Frizzi (son)

(Address) 10 Locust St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

19362

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



JAN 16 1964 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

271

11892

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



STANDARD CERTIFICATE OF DEATH

Registered No.

No. Massachusetts General Hospital BAKER MEMORIAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Antonio Mandilo,

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

85 Quincy Avenue, Winthrop Massachusetts

(a) Residence. No.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 26, 1963
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from November 17, 1963 November 26, 1963

Last saw him alive on November 26, 1963, death is said to have occurred on the date stated above, at 7:50pm

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE PANCREATITIS

INTERVAL BETWEEN ONSET AND DEATH

Weeks

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

MYOCARDIAL INFARCTION OLD HEALED

YEARS

Was autopsy performed?

Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) M. D.

Charles L. Cloy, M.D.
(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l Hosp. 11-27-63

Winthrop Cemetery Winthrop.

6 Place of Burial or Cremation (City or Town) 63.

DATE OF BURIAL Nov 30. 19.

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby.

ADDRESS 210 Winthrop St. Winthrop.

Received and filed

DEC 2 1963

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

Male

9 COLOR

White

10 SINGLE

(write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Married

11 If married, widowed, or divorced

HUSBAND of

Flavia Pino

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE

38

Years

Months

Days

If under 24 hours

Hours.....Minutes

13 Usual Occupation:

contractor

(Kind of work done during most working life)

14 Industry or Business:

Roofs

016 26 9423

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Italy

17 NAME OF FATHER

Dominico

MANDILE

18 BIRTHPLACE OF FATHER (City)

(State or country)

Italy

19 MAIDEN NAME OF MOTHER

Margarita Mandilo

20 BIRTHPLACE OF MOTHER (City)

(State or country)

Italy

21 Informant (Address)

Mrs. Flavia Mandilo

85 Quincy Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

William H. Rice.
City Registrar

RECEIVED



JAN 16 1964 AM

For burial permit
of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

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for each
(b) and (c)

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heart failure,
etc. It means
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which caused

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cause (a),
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the terminal
condition given

330
70

24 1964

Director

use only

CK Ink.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

272

(City or Town making this return)

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD CERTIFICATE OF DEATH

Registered No. 12103

No. MASSACHUSETTS GENERAL HOSPITAL

Catena

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number) }

PHYSICIAN — IMPORTANT

2 FULL NAME Catena Stocco

(If deceased is a married, widowed or divorced woman, give also maiden name.)

20

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 29 Harvard St.
(Usual place of abode)

St. Winthrop Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 9 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 2, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec. 2, 1963, to Dec. 2, 1963

last saw her alive on Dec. 2, 1963, death is said to
have occurred on the date stated above, at 1:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Subarachnoid Hemorrhage

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS
Iron Deficiency Anemia

INTERVAL
BETWEEN
ONSET AND
DEATH

2 hours

Was autopsy performed? no
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify cell

(Signature) Charles L. Cloy, M. D.

Charles L. Cloy, M.D.
(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Dec. 2, 1963

6 St. Michael Cemetery Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 5, 1963

7 NAME OF FUNERAL DIRECTOR Anthony P. Kapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed DEC 5 1963

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN married

11 If married, widowed, or divorced

HUSBAND of
(Give maiden name of wife in full)

(or) WIFE of Frank Stocco
(Husband's name in full)

12 AGE 50 Years.....Months.....Days If under 24 hours
Hours.....Minutes

13 Usual Occupation: Stitcher
(Kind of work done during most working life)

14 Industry or Business: Crown Dress Mfg. Co.

15 Social Security No. 011-05-5020

16 BIRTHPLACE (City)
(State or country) Italy

17 NAME OF FATHER Frank Alois

18 BIRTHPLACE OF FATHER (City)
(State or country) Italy

19 MAIDEN NAME OF MOTHER Maria Ligotti

20 BIRTHPLACE OF MOTHER (City)
(State or country) Italy

21 Informant (Address) Frank Stocco (husband)
20 Harvard St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

Frank Stocco
(Signature of Agent of Board of Health or other)
1963 12/2/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane

City Registrar

RECEIVED



JAN 24 1964 AM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Revere

273

(City or Town making this return)

Suffolk

(County)

Revere

(City or Town)

COPY OF
CERTIFICATE OF DEATH

Registered No.

No. 400 Revere Beach

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George N. Dracos
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR, No

(a) Residence, No. 40 Sea View Ave.
(Usual place of abode)

Winthrop
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 2.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 5, 1963
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 27, 1960 to Dec. 5, 1963
I last saw him live on Dec. 4, 1963 death is said to have occurred on the date stated above, at 12:35P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease

Due To Arteriosclerosis
(b) generalized

Due To
(c) OTHER SIGNIFICANT CONDITIONS Idiopathic Parkinsonism

INTERVAL BETWEEN ONSET AND DEATH

2yrs.

5yrs.

5yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical findings

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) John F. Collins, M. D.

(Address) 27 Bennington St. 12/6 63
Revere Date 19

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 7, 1963

7 NAME OF FUNERAL DIRECTOR Paul K. Babalas

ADDRESS 336 Broadway, Cambridge

Received and filed JAN 15 1964 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Mary Rodes
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 71 Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation Grocery Store
(Kind of work done during most working life)

14 Industry or Business Retired

15 Social Security No. 013-28-7332

16 BIRTHPLACE (City) Greece
(State or country)

17 NAME OF FATHER Nicholas Dracos

18 BIRTHPLACE OF FATHER (City) Greece
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Spelios

20 BIRTHPLACE OF MOTHER (City) Greece
(State or country)

21 Informant Mary Dracos
(Address) 40 Sea View Ave., Winthrop

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED December 9, 1963

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RECEIVED



JAN 15 1964 AM

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burial permit
of Health
Agent.

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The Commonwealth of Massachusetts

274

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No.

12226

PLACE OF DEATH

Suffolk
(County)Boston
(City or Town)

No. Boston Sanatorium

St. (If death occurred in a hospital or institution,
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Irene T. Norris
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a
U. S. War Veteran, NO
if so specify WAR)(a) Residence. No. 95 Loring Road, Winthrop, Mass. St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. 9 months. days. In place of residence 22 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 6, 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from
Feb. 25, 1963, to December 6, 1963I last saw him on December 6, 1963 death is said to
have occurred on the date stated above, at 3:45a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bilateral Lobar Pneumonia
probably tuberculous

(b) Due To Arteriosclerotic Heart

(c) Due To Disease with old antero-
septal myocardial infarct
and acute myocardial
extension.OTHER
SIGNIFICANT
CONDITIONSINTERVAL
BETWEEN
ONSET AND
DEATH

Was autopsy performed? Yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) David S. Sherman, M. D.

SHERMAN

(Address) 249 Rte 1
Mattapan

Date Dec 6 1963

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 9 1963

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP DEC 10 1963

Received and filed

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(or) WIFE of JOHN M. NORRIS
(Give maiden name of wife in full)
(Husband's name in full)12 AGE 76 Years Months Days If under 24 hours
Hours Minutes13 Usual Occupation: HOME MAKER
(Kind of work done during most working life)

14 Industry or Business: HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) NOTH BROOKFIELD
(State or country) MASS.

17 NAME OF FATHER GILBERT MORRISON

18 BIRTHPLACE OF FATHER (City) SCOTLAND.
(State or country)

19 MAIDEN NAME OF MOTHER ANNE T LONG

20 BIRTHPLACE OF MOTHER (City) ST. JOHNS
(State or country) N.B.

21 Informant (Address) MRS CATHERINE CURRAN

72 TRENTON ST MELROSE MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:Frank P. Gaca
(Signature of Agent of Board of Health or other)311614 Dec. 8, 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane
City Registrar

RECEIVED



JAN 24 1964 AM

A TRUE COPY ATTEST.

William J. Kane.

City Registrar

RECEIVED



JAN 24 1964 AM

For burial permit
of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

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OR CAUSES
DEATH

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heart failure,
etc. It means
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condition given

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OUT - OF - TOWN The Commonwealth of Massachusetts

SUFFOLK

(County)

BOSTON

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

276

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 12419

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Carlen
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran, No
if so specify WAR)

(a) Residence. No. Shore Drive st. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 1 months 1 days. In place of residence 38 years 0 months 0 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 12 63
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That attended deceased from
November 11 63 to December 12 63

last saw him live on December 12 19 63 death is said to
have occurred on the date stated above, at 2:08 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary Embolus

Due To (b) Atrial fibrillation

Due To (c)

OTHER SIGNIFICANT CONDITIONS Coronary Heart Disease

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify cellar

(Signature) Charles L. Clay, M.D. M. D.
(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l Hosp. Date Dec. 12 19 63

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 14 19 63

7 NAME OF FUNERAL DIRECTOR Ernest Pagnano

ADDRESS 147 Winthrop St Winthrop

Received and filed William Kane 19 63

DEC 17 1963

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED SINGLE
DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 34 Years 3 Months 11 Days If under 24 hours
Hours Minutes

13 Usual Occupation Home maker
(Kind of work done during most working life)

14 Industry or Business at Home

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass

17 NAME OF FATHER James Carlin

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Alice Curtis

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant (Address) Mrs John Mc Carthy
79 Lincoln St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
19656 12/13/63
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.

City Registrar



JAN 24 1964 AM

for burial permit
ard of Health
ts Agent.

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CERTIFICATE

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etc. It means
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death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 12333

PLACE OF DEATH

SUFFOLK
(County)
BOSTON
(City or Town)



NEW ENGLAND BAPTIST HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME WILLIAM J. KELLEHER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) NO

(a) Residence, No. 184 CIRCUIT ROAD St. WINTHROP MASS
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, 18 years, 30 months, 30 days. In place of residence, 30 years, 30 months, 30 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC 12 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from
NOV 24, 1963, to DEC 12, 1963
I last saw him alive on DEC 11, 1963 death is said to
have occurred on the date stated above, at 1:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ASPIRATION PNEUMONIA

Due To RECURRENT CARCINOMA OF TONGUE
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? NO
What test confirmed diagnosis? BIOPSY

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) WADYSLAW Z. ZUREK M. D.
(Print or Type Name)
605 COMMONWEALTH AVE BOSTON, Date 12/12 1963
(Address)

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 14 1963

7 NAME OF DIRECTOR MAURICE W. HIRBY
ADDRESS 210 C WINTHROP ST. WINTHROP MASS

Received and filed
16 1963
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of ELIZABETH TYRRELL
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

12 AGE 60 Years Months Days If under 24 hours
Hours Minutes

13 Usual Occupation: LAWYER.
(Kind of work done during most working life)

14 Industry or Business: L.H.W.

15 Social Security No. 023-01-2508

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

17 NAME OF FATHER DENNIS J. KELLEHER

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS

19 MAIDEN NAME OF MOTHER CATHERINE O'GRADY

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS

21 Informant (Address) MRS ELIZABETH KELLEHER
184 CIRCUIT RD WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

16 1963
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



JAN 24 1964 AM

burial permit
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OUT - OF - TOWN

SUFFOLK

(County)

ROXBURY

(City or Town)

PLACE OF DEATH



The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

278

(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

Registered No. 12392

JEWISH MEMORIAL HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPH PERLMUTTER

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 62 LOCUST STREET. WINTHROP

(Usual place of abode)

(City or town and State)

Length of stay: In place of death 9 years 9 months 45 days. In place of residence 45 years 9 months 45 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DECEMBER 12 1963

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from DECEMBER 4 1963 to DECEMBER 12 1963

I last saw him alive on DECEMBER 12 1963 death is said to have occurred on the date stated above, at 8:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHO-PNEUMONIA

INTERVAL
BETWEEN
ONSET AND
DEATH
DAYS

Due To
(b)

Due To
(c)

OTHER
SIGNIFICANT
CONDITIONS

CERERAL ARTERY
THROMBOSIS WITH RIGHT
HEMIPLEGIA and APHASIA

MONTH

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Marc Hacamuli M. D.

(Print or Type Name)

JEWISH MEMORIAL HOSP Date 12.12. 1963

6 Cherita MISHNAAS WOBURN

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL DECEMBER 13 1963

7 NAME OF FUNERAL DIRECTOR TORF funeral Service

ADDRESS Washington Ave Chelsea

Received and filed 19.

DEC 16 1963

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

M

White

MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced HUSBAND of LENA GRUND (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12

AGE 75 Years Months Days

If under 24 hours Hours Minutes

13 Usual

Occupation: CARPENTER (Kind of work done during most of working life)

14 Industry

or Business: Building

15 Social Security No.

16 BIRTHPLACE (City)

(State or country) Russia

17 NAME OF

FATHER URBER PERLMUTTER

18 BIRTHPLACE OF

FATHER (City) Russia

19 MAIDEN NAME

OF MOTHER (CIBK)

20 BIRTHPLACE OF

MOTHER (City) Russia

(State or country)

21 Informant HERBERT PERLMUTTER

(Address) 51 Willow Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

24 1964

A TRUE COPY ATTEST:

William J. Kane.
City Registrar

RECEIVED



JAN 24 1964 AM

For burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

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24 1964

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

279

(City or Town making this return)

12435

Registered No.

PLACE OF DEATH

Boston
(County)
Suffolk
(City or Town)



STANDARD CERTIFICATE OF DEATH

No. BOSTON CITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lillian Locke
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence. No. 104 Highland Avenue Winthrop, Mass.
(Usual place of abode) St. (City or town and State)

Length of stay: In place of death 2 1/2 years. In place of residence 70 years.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 13, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, was a patient
Dec. 10, 1963 to December 13, 1963

I saw death is said to

have occurred on the date stated above, at 12:55A.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Shock

Due To Acute myeloblastic leuk-

(b) emia.

Due To

(c)

OTHER

SIGNIFICANT

CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Winthrop O'Connell, M. D.

M. WINTHROP O'CONNELL M.D.

(Print of Type Name)

BOSTON CITY HOSPITAL Date 12-13-63

6 GLENWOOD CEMETERY EVERETT

Place of Burial or Cremation (City or Town)

DATE OF BURIAL DECEMBER 16 1963

7 NAME OF FUNERAL DIRECTOR R.C. KIRBY, INC.

ADDRESS 917 BENNINGTON ST. E. BOSTON

Received and filed DEC 15, 1963

Signature of Registrar

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of CLARENCE B. LOCKE (Husband's name in full)

12 AGE 70 Years 9 Months 11 Days If under 24 hours Hours Minutes

13 Usual Occupation HOUSEWORK (Kind of work done during most of working life)

14 Industry or Business AT HOME

15 Social Security No. NO

16 BIRTHPLACE (City) EAST BOSTON, MASS (State or country)

17 NAME OF FATHER CHARLES MORRISON

18 BIRTHPLACE OF FATHER (City) PRINCE EDWARD IS. (State or country)

19 MAIDEN NAME OF MOTHER CIBL

20 BIRTHPLACE OF MOTHER (City) PRINCE EDWARD IS. (State or country)

21 Informant MR. EVERETT LOCKE

(Address) 112 MARION ST. E. BOSTON, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

Signature of Registrar

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.

City Registrar



JAN 24 1964 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Cambridge 280
(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Cambridge

(City or Town)



COPY OF
CERTIFICATE OF DEATH

Registered No. 1825

No. Guardian Hospital

{(If death occurred in a hospital or institution,
St. { give its NAME instead of street and number)}

2 FULL NAME Edith Lampel
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a
U. S. War Veteran,
if so specify WAR,

(a) Residence. No. 33 Dolphin Ave.
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death. 13 years. 13 months. 13 days. In place of residence. 16 years. 16 months. 16 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 19, 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
Dec. 6, 63 to Dec. 19, 63
I last saw him alive on Dec. 18, 1963, death is said to
have occurred on the date stated above, at 5: A. M.

INTERVAL
BETWEEN
ONSET AND
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypostatic Pneumonia

12/6/63 GE. 12 years. 11 months. 3 days

(b) Due To Cerebral Hemorrhage

12/1/63 13 Usual Occupation: Housework
(Kind of work done during most working life)

(c) Due To Hypertension

14 Industry or Business: At Home

OTHER SIGNIFICANT CONDITIONS Intercebereal Hematoma

15 Social Security No. no
16 BIRTHPLACE (City) Leeds
(State or country) Maine

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Vincent W. Sena, M. D.

(Address) 1196 Broadway, Som. 12-19, 63

Gothsemane Cem. West Roxbury

6 Place of Burial or Cremation Dec. 20, 63
(City or Town)

DATE OF BURIAL 19

7 NAME OF FUNERAL DIRECTOR J.S. Faterman
by David H. Cos

ADDRESS Boston, Mass. auth. Agent

Received and filed JAN 13 1964 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)
MARRIED WIDOWED DIVORCED UNKNOWN Widowed

11 If married, widowed, or divorced
HUSBAND of David Lampel
(Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 GE. 12 years. 11 months. 3 days If under 24 hours
Hours Minutes

13 Usual Occupation: Housework
(Kind of work done during most working life)

14 Industry or Business: At Home

15 Social Security No. no
16 BIRTHPLACE (City) Leeds
(State or country) Maine

17 NAME OF FATHER Frank Lindsey

18 BIRTHPLACE OF FATHER (City) Lewiston
(State or country) Maine

19 MAIDEN NAME OF MOTHER (c.n.b.l.) Lane

20 BIRTHPLACE OF MOTHER (City) Lewiston
(State or country) Maine

21 Informant (Address) Irvin Lampel
42 Hiawatha Rd.
Mattapan

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Dec. 20, 1963

SPACE FOR ADDITIONAL INFORMATION
DATE OF ENTERING MILITARY SERVICE.....
DATE OF DISCHARGE.....
RANK, RATING
ORGANIZATION AND OUTFIT.....
SERVICE NUMBER.....

RECEIVED



JAN 13 1964 AM

FORM R-301

ed for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
AL CERTIFICATE

ET OR TYPE
OR CAUSES
DEATH

not enter
re than one
se for each
, (b) and (c)

does not mean
ode of dying,
a heart failure,
a, etc. It means
cause, or compli-
which caused

itions, if any,
h gave rise to
e cause (a),
ng the under-
cause last.

conditions contrib-
to death but not
to the terminal
condition given

153.8
47
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24 1964

24 1964

12-62-934553

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

281
(City or Town making this return)

STANDARD
CERTIFICATE OF DEATH

12717
Registered No.

PLACE OF DEATH

OUT-OF-TOWN

Suffolk

(County)

Boston

(City or Town)

No. Veterans Administration Hospital

(If death occurred in a hospital or institution,
give its NAME instead of street and number)
PHYSICIAN — IMPORTANT

2 FULL NAME

KENNETH G. SHIPLEY

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR) WWI

(a) Residence, No. 110 Hermon
(Usual place of abode)

s. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years 1 months 28 days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 20 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
October 22, 1963 to December 20, 1963

death is said to
have occurred on the date stated above, at 4:06 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction (1 Day)

Due To (b) Bronchopneumonia right & left
lower lobes.

Due To (c) postoperative adenocarcinoma
of sigmoid.

OTHER
SIGNIFICANT
CONDITIONS

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Paul W. Dishart, M. D.

(Address) VAH Boston, Mass. Date Dec. 21 1963

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 23 1963

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
210 Winthrop St.

ADDRESS Winthrop, Mass.

Received and filed

William J. Rice

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Catherine O'Connell
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 68 years 7 Months 17 Days If under 24 hours
Hours Minutes

13 Usual Occupation Merchant Seaman
(Kind of work done during most of working life)

14 Industry
or Business

15 Social Security No. 030 10 5156

16 BIRTHPLACE (City), Annapolis
(State or country) Maryland

17 NAME OF FATHER William T. Shipley

18 BIRTHPLACE OF FATHER (City) Annapolis
(State or country) Maryland

19 MAIDEN NAME OF MOTHER Bessie Curry

20 BIRTHPLACE OF MOTHER (City) Annapolis
(State or country) Maryland

VA Hospital Records, 150 So.

21 Informant Huntington Ave., Boston, Mass.

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



JAN 24 1964 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

282

PLACE OF DEATH

Essex
(County)

Danvers
(City or Town)



COPY OF CERTIFICATE OF DEATH

(City or Town where this return)

Registered No.

No. Danvers State Hos. Hathorne

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Harry A. Spector

2 FULL NAME. (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR,

230 Shore Drive, Winthrop, Mass.

(a) Residence. No. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death. 0 years. 0 months. 11 days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 21, 1963
(Month) (Day) (Year)

Dec. 10, 1963 Dec. 21, 1963
I last saw h. alive on Dec. 21, 1963
have occurred on the date stated above, at m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
bronchopneumonia

(a)

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS
coronary ht dis.
yes

INTERVAL
BETWEEN
ONSET AND
DEATH

Was autopsy performed? autopsy

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify Willard M. Hausman

(Signed) Willard M. Hausman, M. D.

Hathorne, Mass. 12.24 63

(Address) Askinago, Everett, Mass.

6 Place of Burial or Cremation December (City or Town) 63

DATE OF BURIAL Torf Funeral Service Inc.

7 NAME OF FUNERAL DIRECTOR
Chelsea, Mass.

ADDRESS Dec. 27, 1963

Received and filed FEB 26 1964 19.

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)
MARRIED married
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed or divorced
HUSBAND of Kay Goddess
(Give maiden name of wife in full)

(or) WIFE of

12 AGE 60 09 19
Years. Months. Days. If under 24 hours
Hours. Minutes

13 Usual Occupation: Mgr. cleaning Est.
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. London

16 BIRTHPLACE (City) England
(State or country)

17 NAME OF FATHER Daniel Spector

18 BIRTHPLACE OF FATHER (City) unknown
(State or country)

19 MAIDEN NAME OF MOTHER Sadie Mizzale

20 BIRTHPLACE OF MOTHER (City) unknown
(State or country) Russia

21 Informant Address) Georgie T. Brimigion

Danvers, Mass.

A TRUE COPY

ATTEST: Registrar of City or Town where death occurred

DATE FILED 19.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

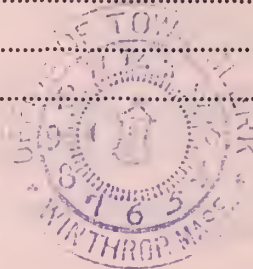
DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

.....



FEB - 6 1964 PM

not enter
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
cause, or compli-
which caused

itions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
to death but not
to the terminal
condition given

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81
x70

al Director
se use only
ACK Ink.

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

283

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 13137

No. MASSACHUSETTS GENERAL HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Albert Lythgoe
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a
U. S. War Veteran,
if so specify WAR)

(a) Residence, No. 23 Fairview
(Usual place of abode)

St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death years months 2 days. In place of residence 74 years 0 months 23 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 27 1963
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from
December 24, 1963, to December 27, 1963
we last saw him alive on December 27, 1963 death is said to
have occurred on the date stated above, at 12:30 Noon

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL INFARCTION

INTERVAL
BETWEEN
ONSET AND
DEATH

9 DAYS

(b) Due To CORONARY THROMBOSIS

9 DAYS

(c) Due To

OTHER SIGNIFICANT CONDITIONS EMPHYSEMA

YEARS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Dec. 27, 1963

6 Place of Burial or Cremation Everett
(City or Town)

DATE OF BURIAL Dec. 27 1963

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS

Received and filed

JAN 2 1964

(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 74 Years 0 Months 23 Days
If under 24 hours
Hours Minutes

13 Usual Occupation: (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country)

17 NAME OF FATHER George Lythgoe

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Judith D. Bellamy

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant (Address) Edith Lythgoe
23 Fairview St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

VAV

A TRUE COPY ATTEST:

William J. Kane.
City Registrar



FEB 10 1964 AM

1 for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

oes not mean
e of dying,
heart failure,
etc. It means
se, or compli-
which caused

ons, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

1201
81
70
3 10/1/64

al Director
se use only
ACK Ink.

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

113 116 Lincoln St. - Boston

2 FULL NAME Nicholas Linardi
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 789 Shirley
(Usual place of abode)St. Winthrop, Mass.
(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 6 days. In place of residence 35 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 30 1963
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I died deceased from
December 24 1963, to December 30 1963I last saw him alive on December 30 1963, death is said to
have occurred on the date stated above, at 7:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Heart Disease,
severeDue To
(b)Due To
(c)OTHER
SIGNIFICANT
CONDITIONSStatus post-operative 3 days
for acute cholecystitis

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Charles L. Clay, M.D., M. D.

(Print or Type Name)

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Dec. 30 1963

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 3 1963

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed JAN 6 1964

A TRUE COPY ATTEST:



KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 13185

(If death occurred in a hospital or institution,
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a
U. S. War Veteran,
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male	9 COLOR White	10 SINGLE (write the word) MARRIED WIDOWED Widowed DIVORCED UNKNOWN
---------------	------------------	---

11 If married, widowed, or divorced
HUSBAND of Mary Gorska
(Give maiden name of wife in full)(or) WIFE of
(Husband's name in full)12 AGE 93 Years Months Days
If under 24 hours Hours Minutes13 Usual Occupation Retired
(Kind of work done during most working life)

14 Industry or Business S S Captain

15 Social Security No.

16 BIRTHPLACE (City) Sam Martino DeChiesa
(State or country) Austria

17 NAME OF FATHER Giovanni Linardi

18 BIRTHPLACE OF FATHER (City) Austria
(State or country)

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) Austria
(State or country)21 Informant Archie Moriarty
(Address) 789 Shirley St.,I HEREBY CERTIFY that a satisfactory standard certificate of death
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

19922 1-1-64
(Official Designation) (Date of Issue of Permit)

(Registrar)

A TRUE COPY ATTEST:

William J. Kane.

City Registrar



FEB 10 1964 AM



